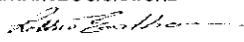


DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 12/10/2013
FORM APPROVED
OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2013	
NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER		STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X6) COMPLETION DATE
F 000	<p>INITIAL COMMENTS</p> <p>*Amended</p> <p>A standard health survey was initiated on 10/08/13 and concluded on 10/23/13. Immediate Jeopardy was identified on 10/11/13 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and 483.75 Administration (F490 and F520), at a scope and severity of "J" with Substandard Quality of Care at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) which was determined to exist on 09/25/13. The facility was notified of the Immediate Jeopardy on 10/11/13. Review of the facility's 185 Grievance/Complaint Reports since the last standard survey conducted on 09/11/12, revealed at least 8 of these reports were allegations of abuse/neglect and 8 were allegations of misappropriation of resident property. The facility failed to provide evidence the 16 Grievance/Complaint Reports had been reported to the appropriate state agencies and failed to provide evidence protection had been provided for the residents after the allegation had been reported to facility staff. In addition, the facility failed to ensure each allegation was investigated by ensuring all witnesses and potential witnesses were interviewed, residents (victims of alleged abuse) were observed and assessed, and record review was completed as indicated, etc.</p> <p>An extended survey was conducted on 10/22-23/13. No additional concerns were identified.</p> <p>The facility provided an acceptable credible Allegation of Compliance (AOC) on 10/21/13 with</p>	F 000	<p>The preparation and execution of this plan does not constitute admission or agreement by the provider of truth of the facts alleged or conclusions set forth in the statement for deficiency. The plan of correction is prepared and executed solely because it is required by Federal and State law.</p>	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE



TITLE
EXECUTIVE DIRECTOR

(X6) DATE
12/12/2013

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

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F 000	Continued From page 1 the facility alleging removal of the Immediate Jeopardy on 10/22/13. The State Survey Agency (SA) verified removal of the Immediate Jeopardy on 10/22/13, as alleged in the acceptable AOC, with remaining noncompliance at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and 483.75 Administration (F490 and F520), at a scope and severity of "D" while the facility develops and implements a plan of correction and monitors the effectiveness of systemic changes and quality assurance activities.	F 000	The preparation and execution of this plan does not constitute admission or agreement by the provider of truth of the facts alleged or conclusions set forth in the statement for deficiency. The plan of correction is prepared and executed solely because it is required by the Federal and State law.		
F 225 SS=J	Additional deficiencies were cited as a result of the standard survey in the areas of 42 CFR 483.15 Quality of Life (F253 - S/S "D"), 42 CFR 483.20 Resident Assessment (F282 - S/S "D"), and 42 CFR 483.35 Dietary Services (F363 - S/S "E" and F371 - S/S "D"). 483.13(c)(1)(ii)-(iii), (c)(2) - (4) INVESTIGATE/REPORT ALLEGATIONS/INDIVIDUALS The facility must not employ individuals who have been found guilty of abusing, neglecting, or mistreating residents by a court of law; or have had a finding entered into the State nurse aide registry concerning abuse, neglect, mistreatment of residents or misappropriation of their property; and report any knowledge it has of actions by a court of law against an employee, which would indicate unfitness for service as a nurse aide or other facility staff to the State nurse aide registry or licensing authorities. The facility must ensure that all alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source and	F 225	F 225 1. Residents #1, #5, #6, #7, #9, and "B" were physically assessed immediately for any signs or symptoms of abuse. There were no signs or symptoms of abuse found and their cases were re opened. The residents were immediately protected, and thorough investigations were performed as follows: F 225 Continued next page...		

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F 225	<p>Continued From page 2</p> <p>misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with State law through established procedures (including to the State survey and certification agency).</p> <p>The facility must have evidence that all alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.</p> <p>The results of all investigations must be reported to the administrator or his designated representative and to other officials in accordance with State law (including to the State survey and certification agency) within 5 working days of the incident, and if the alleged violation is verified appropriate corrective action must be taken.</p> <p>This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's investigations and abuse procedures, it was determined the facility failed to ensure allegations of resident abuse, neglect, including injuries of unknown source, and misappropriation of resident property were reported immediately to the State Survey Agency and other officials in accordance with state law for six of fifteen sampled residents (Residents #1, #5, #6, #7, #9, and #11) and one unsampled resident (Resident B). The facility failed to ensure all allegations were investigated by ensuring all witnesses and potential witnesses were interviewed, physical assessments were completed when indicated, and record reviews were completed when indicated, etc. In addition, the facility failed to</p>	F 225	<p>F 225 Continued ...</p> <p>RSD #1</p> <p>Allegation: Mental Abuse, Original Date: 6/6/2013, Re-opened date: 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: (RSD #1) had inappropriate comments written on brief; (employee) was suspended by DON. An investigation was completed by the use of interviews with staff working at the time of incident as well as residents residing on the same unit. A head to toe assessment was completed on this resident by the DON, there were no bruising, skin tears or other evidence of injury found. Conclusion: It was found through interviews with staff, the message written on the brief was not intended for the resident. It was intended for another employee in a playful manner that would be checking the residents brief on next round. Unsubstantiated and re-educated (was placed on Follow-up Nursing/Facility Staff Performance Program, in which an a staff member is given specific goals related identified issues or potential issues to be reached and maintained throughout the program and is monitored daily while at work by Direct Nursing Staff and Supervisors and meets weekly with DON</p> <p>F 225 Continued NEXT PAGE...</p>	

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F 225	<p>Continued From page 3</p> <p>ensure residents were protected from further potential abuse during the investigation.</p> <p>The facility had documented 185 Grievance/Complaint Reports since the last standard survey conducted on 09/11/12. It was determined at least eight of these reports were allegations of abuse/neglect and eight were allegations of misappropriation. However, the facility failed to report these allegations of abuse and misappropriation to the appropriate state agencies, failed to protect residents from further potential abuse during the investigations of these allegations, and failed to ensure the facility's investigation included witness and potential witness interviews, physical assessments when indicated, and record reviews, etc. The facility failed to ensure the implementation of policies and procedures to protect residents after allegations of abuse, neglect, exploitation, and misappropriation of resident personal property were reported and investigated.</p> <p>On 09/25/13, Resident #7 reported a nurse aide was rough with him/her during care and had "jerked" his/her arm and leg on 09/24/13. In addition, Resident #7 reported a night shift aide was "mean" to him/her on 09/11/13. However, the facility failed to report the allegations to the appropriate state agencies, failed to assess the resident for injury, and failed to protect residents from further potential abuse during the investigation of the allegations. In addition, six additional reports of alleged abuse, neglect, and exploitation were identified: Resident #9 reported staff refused to toilet him/her timely and reported he/she was "squeezed" when being transferred by facility staff; staff reported inappropriate markings were discovered on Resident #1's brief;</p>	F 225	<p>F-225 Continued...</p> <p>ADON for one month for any reoccurrences of complaints or infractions and quality of care being rendered) (See Exhibit #11, Follow-up Nursing/Facility Staff Performance Program Policy and Form)</p> <p>RSD #5 Allegation: Physical Abuse, Original Date: 4/9/2013, Re-opened date: 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: RSD #5 states that (SRNA) pushed her, RSD protected, an investigation was conducted by use of interview with SRNA and (Resident #5) as well as interviews with other staff and residents on the same unit. A head to toe assessment was performed on RSD #5 that revealed no signs or symptoms of abuse were present, including but not limited to bruising, or skin tears. Conclusion: Resident is care planned for non compliance of care; this includes the use of Medical Bi PAP Machine. A determination was made that SRNA (employee) assisted RSD #5 down in the wheelchair to keep her from falling. The resident was exhibiting signs of extreme confusion and lethargy</p> <p>F 225 Continued next page...</p>		

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F 225	<p>Continued From page 4</p> <p>Resident #5 alleged staff "pushed" him/her in the back; staff failed to administer medication as reported for Resident #6; and staff failed to provide appropriate care during mealtime involving Resident B. In addition, the facility failed to report eight allegations of residents' missing monies (Residents #9, #11, D, E, F, and G) and failed to investigate the allegations by not interviewing the residents and staff caring for the residents involved.</p> <p>The facility's failure to immediately report all allegations of abuse, neglect, exploitation, and misappropriation of resident property, failure to protect residents during the course of an investigation of abuse, and failure to investigate an allegation of abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy with Substandard Quality of Care was determined to exist on 09/25/13 at 42 CFR 483.13 Resident Behavior and Facility Practices and 42 CFR 483.75 Administration. The facility was notified of the Immediate Jeopardy on 10/11/13.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 10/22/13, which alleged removal of Immediate Jeopardy on 10/22/13. The State Survey Agency determined the Immediate Jeopardy was removed on 10/22/13, which lowered the scope and severity to "D" while the facility monitors the effectiveness of systemic changes and quality assurance activities.</p> <p>The findings include:</p> <p>Review of the facility's policy, "Abuse," (revised 01/23/13) revealed facility staff was to immediately report any incident of observed or</p>	F 225	<p>F 225 Continued...</p> <p>Secondary to refusal to wear a Bi Pap Machine, potentially causing Resident #5 confusion, sleepiness, and to be slow moving. SRNA stated that she felt RSD #5 was going to fall over her bedside table so she (SRNA) sat her in the wheelchair to keep her from falling. SRNA is no longer employed with the facility. This was on going and completed on October 17, 2013. Appropriate state agencies were immediately notified.</p> <p>RSD #6 Allegation: Neglect, Original Date: 8/29/2013, Re-opened date: 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: Resident family stated RSD #6 did not receive his 1400 dose of Risperadol. An immediate head to toe assessment was completed; a thorough investigation was performed by interviewing all the nurses that had provided care to this resident and dispensed medications from the residents cart, a complete count of the Risperadol was performed. The count of the drug was correct, the MAR revealed that the Risperadol was given and signed out on the MAR. An interview with the RN revealed that the medication was given per physician orders. The resident had not had an increase in behaviors or agitation.</p> <p>F-225 Continued next page...</p>		

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F 225	<p>Continued From page 5</p> <p>suspected abuse, neglect, or misappropriation of resident property to the Charge Nurse after removing the resident from harm. If an employee was suspected of abuse, he/she would be sent home pending an investigation. Further review of the facility's policy revealed the Charge Nurse would immediately report the allegation to the facility's Social Services Director (SSD), Administrator, and the Director of Nursing (DON). The resident would then be examined by the Charge Nurse. The SSD and DON would immediately initiate an "Abuse Incident Report" and start the investigation. During the investigation process the involved staff member would be reassigned or suspended, at the discretion of the DON or Administrator. The policy also revealed the SSD would immediately notify the Department for Community Based Services (DCBS) and the Office of Inspector General (OIG). In addition, the SSD was responsible to collect all information and documentation of the alleged abuse and fax to DCBS and OIG within five working days after receipt of the allegation.</p> <p>1a. Review of the medical record revealed the facility admitted Resident #7 on 12/07/12 with diagnoses that included Bipolar Disorder, Joint Pain, General Muscle Weakness, Depression, and Anxiety. Review of the Quarterly Minimum Data Set (MDS) assessment dated 08/04/13, revealed the facility assessed the resident to have a Brief Interview for Mental Status (BIMS) score of 15 which indicated he/she was interviewable.</p> <p>Review of a Grievance/Complaint Report revealed on 09/25/13, Resident #7 reported to Licensed Practical Nurse (LPN) #2 that a night shift Certified Nursing Assistant (CNA) was very</p>	F 225	<p>F-225 Continued...</p> <p>RSD #7 Allegation: Physical Abuse Original Date: 9/25/2013, Re-opened date: 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: RSD #7 <u>alleged</u> that an aide was rough with care, In an interview with the roommate and resident it was alleged that CNA #4 instructed them (Residents) not to ring the call light as well. (This complaint was re-opened October 21, 2013. An investigation was completed with interviews of residents and staff) the CNA #4 (employee) was suspended by DON an investigation was completed, as well as, a physical assessment of resident was performed by DON and no injuries were noted such as bruising, skin tears, abrasions etc. Conclusion: Statements were taken from other residents and employees. Upon further questioning of other residents, one other resident voiced complaint related to the roughness in care provided by CNA #4 and Resident #7. The complaint from Resident #7 was investigated thoroughly, reported in a timely manner additional questioning of resident #7 she states that CNA #4 was only rough with her that one time stating that she was in a hurry to put my night gown on, rsd #7 states that employee has never been rough with her before and has not been rough since then. Rsd #7 states that she really likes the CNA #4 and does not mind that she takes care of her</p> <p>F-225 Continued next page...</p>		

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F 225	<p>Continued From page 6</p> <p>rough when she provided his/her evening care on 09/24/13 and "jerked" the resident's arm and leg. Further review revealed the facility interviewed Resident #7 on 09/25/13 and the resident reported that a "red-headed girl, who wore her hair on top of her head" came into his/her room to get him/her ready for bed, and jerked his/her arm and leg while using the "Hoyer" lift (mechanical lift) by herself to put the resident into bed. Resident #7 reported the CNA stated, "I'm in a hurry and have other people to do and have to get out of here," and began "jerking" on him/her while she removed the resident's gown. Resident #7 stated the CNA hurt his/her arm and that he/she asked the CNA not to "be so rough and hateful," and began to cry. According to documentation on the Complaint/Grievance Report, the resident also reported to the facility that he/she felt like the CNA was trying to "mistreat" him/her. Further review of the report revealed the facility identified the "red-headed girl" as CNA #4. The facility had not removed the CNA from direct care during the course of the investigation. Based on a review of the Grievance/Complaint Report, the facility failed to conduct a physical assessment of the resident after the allegation was reported. Continued review of the report revealed the facility had not reported the allegation to the appropriate state agencies and had not taken measures to ensure residents, including Resident #7, were protected from further potential abuse while an investigation of the allegation was conducted.</p> <p>Resident #7 confirmed in interview conducted on 10/12/13, at 6:30 PM that he/she had reported to LPN #2 on 09/25/13 that a staff member was "very rough" and had jerked on his/her "arm and leg" when she assisted the resident to change</p>	F 225	<p>F-225 Continued...</p> <p>Additional questioning took place with the roommate; she states that CNA #4 pulled rsd #7's crippled leg and that rsd #7 told her about it, roommate states that SRNA immediately apologized stating that she did not mean to pull her leg. Roommate states that SRNA has never been rough with her and she has never seen her be rough with any other resident, and that she likes SRNA. SRNA instructed those (Residents) not to ring the call light as well. (This complaint was re-opened October 21, 2013. A thorough investigation was completed with interviews of residents and staff). Upon further investigation with (Resident #7) it was determined that (Employee) stated "Do not put the call light on". RSD #7 also stated that she was unsure as to why (Employee) made that statement. Upon interviewing roommate she stated that (Employee) stated "Don't put your call light on" roommate stated that CNA #4 stated this as she was leaving the room both residents is unsure as to why the statement was made by (Employee). Staff that worked with CNA #4 was interviewed to determine if they knew that CNA #4 would tell residents not to put on the call light. Staff statements reflect that they had never witnessed CNA #4 speaking in that manner to any resident or asking them not to put on their call lights. Interviews with other residents revealed that they had never been told to not put on their call lights by CNA #4.</p> <p>F-225 Continued next page...</p>	

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F 225	<p>Continued From page 7</p> <p>his/her clothing and assist him/her to bed. Resident #7 said that he/she could not recall the staff person's name but had told LPN #2 that it was a "red-headed girl" who worked "night shift" and wore her hair "on top of her head."</p> <p>Interview with CNA #4 on 10/12/13, at 2:30 PM, revealed she worked the night shift on 09/24/13 and had provided care for Resident #7. CNA #4 acknowledged she was in a hurry and had changed Resident #7's clothing prior to using the Hoyer lift, alone, to transfer the resident to the bed. According to CNA #4, Resident #7 thought he/she was going to fall during the transfer and the CNA had assured the resident that she wouldn't let him/her fall. CNA #4 went on to say that she was never aware or informed by the facility's DON or Administrator that there had been an allegation of abuse against her regarding the care provided to Resident #7 on 09/24/13.</p> <p>Interview with the facility's SSD on 10/12/13, at 4:10 PM, revealed Resident #7's allegation was reported to the DON on the morning of 09/25/13 (time unknown). The SSD went on to say that the DON informed her that she would look at the statement from CNA #4 and determine later what action to take. The SSD stated she felt like the resident's report was an allegation of abuse and "I felt I should have called it in but I don't have the authority. It has always been the Administrator's final decision to call it in."</p> <p>During the interview with the DON on 10/12/13, at 2:45 PM, she indicated she felt the allegation was not abuse, and stated, "I felt like it was more of a complaint." The DON went on to say that she thought Resident #7 felt like he/she was being rushed during evening care. The DON said that</p>	F 225	<p>F-225 Continued...</p> <p>It was determined that CNA #4 had established a pattern of complaints and review of past counseling's related to not following care plans, such as resident to be transferred by two person assist with the use of Hoyer lift, it was determined that the potential for abuse and neglect was present if she remained in the facility. A proactive approach was taken in this allegation to terminate the employee preventing any potential abuse, neglect, exploitation or misappropriation from this individual in the future, (Substantiated, Employee Terminated 10/21/2013).</p> <p>RSD #9 Allegation: Neglect, Original Date: 6/13/2013, Re-opened date: 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: (RSD #9) states that (employee) refused to take her to the bathroom, employee was suspended and a thorough investigation was completed. Conclusion: Additional investigation revealed that (Employee) did not refuse to take resident to the toilet as evident by interviews with staff members that were present at the time and residents roommate and residents that lived on the same unit as RSD #9.</p> <p>F-225 Continued next page...</p>		

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F 225	<p>Continued From page 8</p> <p>she put CNA #4 on another wing "due to thinking it was a personality conflict." Further interview with the DON revealed that CNA #4 was never suspended or removed from direct care of the residents at the facility.</p> <p>Interview with the Administrator on 10/12/13, at 2:40 PM, revealed the incident dated 09/25/13 related to Resident #7 was reviewed in the Interdisciplinary Team (IDT) meeting and the team had viewed the report as a complaint and not an allegation of abuse. The facility Interdisciplinary Team (IDT) which included the following staff: Administrator; Director of Nursing; Assistant Director of Nursing; Staff Development Nurse; Social Services Director; Minimum Data Sets Nurse; Director of Finance; Medical Records Director; Managing Partner; Director of Dietary; Housekeeping Director; Director of Maintenance; Unit Coordinator Nurse; Nurse Supervisor and Restorative Program Nurse. The Administrator said that no injury occurred to Resident #7 and therefore he did not feel Resident #7, or other residents in the facility, needed to be protected. The Administrator also stated the IDT had decided not to report the incident to the state agencies.</p> <p>1b. Review of a Grievance/Complaint Report dated 09/11/13, revealed an allegation of possible abuse was reported to the SSD by Resident #7 on 09/11/13. According to the report, Resident #7 alleged that a CNA on the night shift on 09/10/13 was mean to him/her and had not placed the resident's leg on a pillow or administered the resident's pain medication when requested; and staff had also complained that he/she had rang his/her call bell every two to three minutes. Review of the report revealed Resident #7's</p>	F 225	<p>F-225 Continued...</p> <p>RSD #9: Allegation: Physical Abuse, Original Date: 06/05/2013, Re-opened date: 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: (RSD #9) states that a big girl squeezed her. SRNA was suspended by DON and an investigation was conducted which included interviews with Staff that were present and residents on the same unit. A physical assessment was conducted, that revealed no bruising, skin tears or any other signs of abuse. Conclusion: Determination made that accused SRNA did not squeeze (Resident) after interview with SRNA and (Resident). (Resident) stated that she simply did not like the way she was transferred that time. Noted, (Resident) has diagnosis of severe rheumatoid arthritis and continuous generalized pain of entire body. In addition to: Obsessive Compulsive Disorder, Depression and Anxiety requiring mild and soft transfers. Allegation was unsubstantiated; SRNA was re-educated on proper transferring techniques with this resident). SRNA was able to demonstrate how transfer took place, it was noted that transfer was not according to facility policy. Employee did not utilize a gait belt as required with RSD #9. She was immediately directed on how to appropriately transfer this resident by the DON.</p> <p>F-225 Continued next page...</p>		

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F 225	<p>Continued From page 9</p> <p>roommate was also interviewed and reported that the CNA had "jumped" onto them for "ringing the call bell." Resident #7 and his/her roommate were unable to identify the perpetrator. Further review of the facility's Grievance/Complaint Report revealed the SSD had obtained witness statements from Resident #7, the resident's roommate, and staff members that had worked on the night shift on 09/10/13 on the hall of Resident #7. The report revealed the SSD had also interviewed other residents on 09/11/13 that were on the same hall as Resident #7 for any issues/concerns of abuse/neglect and found no complaints of abuse or neglect. Review of the Grievance/Complaint Report revealed no documented evidence the facility conducted further investigation to include physical assessment of possible injuries to the resident and no evidence the allegation was reported to the appropriate state agencies.</p> <p>Interview with Resident #7 on 10/13/13, at 10:58 AM revealed he/she couldn't recall much about the incident dated 09/11/13, but stated a CNA had asked him/her if he/she thought "it's funny ringing the call bell all night."</p> <p>Interview with the SSD on 10/13/13, at 10:05 AM, revealed she initiated a Grievance/Complaint Report on 09/11/13 that she received from housekeeping staff on 09/11/13 and had obtained a statement from Resident #7. The SSD stated she also interviewed six other residents on the same hall as Resident #7 and had not received complaints related to not receiving medication or care needs not met on the night of 09/10/13. The SSD stated that after she talked with Resident #7 she felt like this wasn't abuse or neglect and didn't feel it should be reported to the state</p>	F 225	<p>F-225 Continued...</p> <p>Has diagnosis of severe rheumatoid arthritis and continuous generalized pain of entire body. In addition to: Obsessive Compulsive Disorder, Depression and Anxiety RSD #9, as related to her diagnosis of Obsessive Compulsive Disorder wants to be toileted every 15-30 minutes. She was placed on a Bowel and Bladder Plan by her Physician with interventions including; toilet every 2 hours at specific times. (Employee) was following the plan of care set forth by the Physician, and encouraging RSD #9 to wait until the set time to go. The bowel and bladder plan has been care planned and discussed many times with RSD #9. She is in agreement with the plan. She still continues to ask to go the toilet every 15-30 minutes. Staff continues to re-educate her on a daily basis as to her planned program set forth by her physician. Note: (Resident) has been on the scheduled Bowel and Bladder Program since 1/18/2013. The Allegation was Unsubstantiated, (Employee) was re-educated as to (Resident) specific Bowel and Bladder Program and proper toileting techniques.</p> <p>F-225 Continued next page...</p>		

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F 225	<p>Continued From page 10 agencies. The SSD stated she notified the DON of the complaint on 09/11/13.</p> <p>Interview with the DON on 10/13/13, at 1:00 PM revealed she reviewed the staffing schedule to determine who had worked on 09/10/13 and had provided care to Resident #7. According to the DON, she talked with the staff that had provided care to the resident on that date and there were no concerns identified or reported. In addition, the DON stated that based on review of the Medication Administration Record (MAR), Resident #7 had received his/her pain medications as prescribed. The DON stated after interviews with staff and review of Resident #7's MAR, it was determined the resident had not experienced an "injury" and that "abuse or neglect" had not occurred.</p> <p>Interview with the Administrator on 10/13/13, at 2:58 PM revealed he could not recall the date he was informed of Resident #7's allegation related to the care he/she received on 09/11/13. He stated he had probably been informed in one of the IDT meetings. The Administrator stated facility staff had not followed facility policy related to the investigation of Resident #7's complaints. However, the Administrator stated, after a discussion of the allegation by the IDT he agreed with the findings.</p> <p>2a. Review of the medical record revealed the facility admitted Resident #9 on 01/29/09 with diagnoses that included Obsessive Compulsive Disorder, Depression, Anxiety, Osteoporosis, and Gastritis.</p> <p>Review of a Grievance/Complaint Report dated 06/13/13, revealed Resident #9 reported "a big</p>	F 225	<p>F-225 Continued...</p> <p>RSD "B"</p> <p>Allegations: Neglect, Original Date: 9/25/2013, Re-opened date: 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: A visitor alleges that (RSD "B") was choking and coughing in the dining room, they state the aide did nothing for him and wiped his mouth "hard" (employee) was suspended and a thorough investigation was completed by interviewing staff that were present during meal time as well as other residents that were present. A physical assessment was completed and no adverse affects were noted, lungs were clear, afebrile, vital signs were normal and resident was in no distress. Conclusion: RSD has worked with Speech Therapy and has had a five (5) modified Barium Swallow studies from 6/2012 to 5/2013. The physician is aware and has declined the use of a feeding tube. The RSD is care planned for choking and coughing episodes during meals. Staff is educated to stop feeding and allow him to "Cough and Clear" while being monitored by the feeding staff during these episodes. Unsubstantiated and re-educated as to proper feeding techniques and the potential for this resident to aspirate during feeding and when to alert nursing staff to potential aspiration.</p> <p>F-225 Continued next page...</p>		

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F 225	<p>Continued From page 11</p> <p>guy" on the night shift refused to take the resident to the bathroom. The resident reported the guy said he would return to take him/her to the bathroom but he never returned.</p> <p>Review of a Quarterly Minimum Data Set (MDS) assessment dated 07/25/13, revealed the facility assessed Resident #9 to be alert, oriented, had clear speech, could make needs known, and had a Brief Interview for Mental Status (BIMS) score of 14, which indicated he/she was interviewable. The facility assessed the resident to require the assistance of two staff persons with transfers.</p> <p>Interview with Resident #9 at 9:45 PM on 10/13/13, revealed a big guy told the resident that he/she would have to wait "30 minutes" before he could take him/her to the bathroom. The resident stated, "It hurt my feelings" when the guy told him/her that he/she would have to wait to go to the bathroom. The resident further stated it "made me feel like a thing instead of a person."</p> <p>Interview with the SSD at 11:00 AM on 10/13/13, revealed staff reported to her Resident #9 complained that a "big guy" on the night shift refused to take him/her to the bathroom. The allegation was discussed in the IDT meeting and it was determined the DON would obtain a statement from the alleged perpetrator, and the facility would provide in-service training to staff on 06/20/13. However, review of the in-service dated 06/20/13 revealed abuse, neglect, and exploitation were not specified as topics covered in the in-service.</p> <p>Interview with the DON at 1:20 PM on 10/13/13, revealed she made the decision to not suspend the alleged perpetrator because she did not feel</p>	F 225	<p>F-225 Continued...</p> <p>The facility replaced Residents Monies missing for the following residents #9, #11, D, E, F, and G when incident occurred. Employees were interviewed by the Director of Social Services, to determine events surrounding the missing monies. Residents that live on the same units aside from the RSDs listed above were interviewed. Residents were also interviewed at the time the monies went missing and there was no evidence found to imply that impropriety had occurred other than the disappearance of monies without reason or trace, the facility had replaced the monies. The policy of the facility is that residents are encouraged not to keep money on their person and to have the business office keep their money in the safe and they could get it at any time during the week or weekend. RSD #9 reported \$5.00 was missing on 11/05/12 interviews of staff and other residents did not reveal any information, money was replaced by facility, no evidence of anyone haven it taken was determined. Resident #11 reported \$5.00 was missing from his/her chest at the resident's bedside on 11/20/12, interviews with staff and other residents did not reveal any information, money was replaced by facility, no evidence of anyone haven it taken was determined. On 11/01/12, Resident D reported to the SSD he/she was missing \$4.36, interviews with staff and other residents on the unit did not reveal any information, money was replaced by facility, no evidence of anyone haven it taken was determined. Resident E reported he/she had \$30.00 missing since 11/04/12, interviews with staff and other residents on the unit did not reveal any information. , money was replaced by facility, no evidence of anyone haven it taken was determined.</p> <p>F 225 Continued next page...</p>		

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F 225	<p>Continued From page 12</p> <p>the employee abused/neglected Resident #9. The DON stated she did not feel there was any need to protect the resident because she did not feel abuse/neglect had occurred. The DON acknowledged the facility had only obtained a statement from the alleged perpetrator and that the facility had not reported the allegation to the state agencies.</p> <p>Interview with the Administrator at 2:00 PM on 10/13/13, revealed the allegation was discussed in the IDT meeting. The IDT determined the allegation was not abuse/neglect and that the allegation was not reportable.</p> <p>2b. Continued review of Grievance/Complaint Reports revealed a report dated 06/05/13, which revealed Resident #9 reported on 06/05/13, that a staff member transferred him/her on the second shift from the wheelchair to the commode by herself, squeezed the resident's ribs, and hurt his/her leg.</p> <p>Resident #9 stated in interview at 9:45 AM on 10/13/13, that the girl did not mean to hurt him/her. The resident stated it was the girl's first time caring for him/her, and the girl did not know she needed another staff person to assist with transferring the resident. The resident further stated he/she felt the girl needed more training prior to caring for him/her.</p> <p>Interview with the SSD at 5:50 PM on 10/12/13 revealed staff reported to her on 06/05/13 that Resident #9 had complained that "a big girl" on the second shift (06/04/13) had transferred the resident by herself, squeezed the resident's ribs, and hurt his/her leg. The SSD stated after she interviewed the resident and met with the IDT, it</p>	F 225	<p>F 225 Continued...</p> <p>Monies were replaced by facility for residents F and G as well, interviews with staff working at time the monies went missing and other residents did not reveal any information no evidence of anyone haven it taken was determined.</p> <p>2. The facility through interviews with all residents performed by DSS, MDSN, DON, MRN, Restorative Nurse and physical assessments performed on all residents in the facility by the Director of Nursing. There were five (5) allegations of abuse (1. Rough care in the past, 2. fearful of nurse, 3. RSD-RSD doesn't treat me with respect 4. Fearful of minister 5. Rough care provided), six (6) Misappropriations (1. Missing watch 2. Missing necklace 3. Missing blanket 4. Missing clothes 5. Picture taken from room 6. Missing shirt), Two (2) neglect allegations (1. SRNA refused to take rsd to bathroom, 2. RSD states did not receive shower), issues that was determined to exist. Each resident was protected, any potential perpetrators were removed from the resident care area, each resident was physically assessed from head to toe immediately, all appropriate state agencies were notified immediately and each case was investigated by use of interviews with staff, Residents, family members and other persons as needed.</p> <p>3. Systemic changes such as; Quality Assurance/Risk Management Policy was updated October 13, 2013 to include specific oversight of Abuse, Neglect, Misappropriation oversight and input from Medical Director. (See Exhibit # 10: Quality Assurance Policy).</p> <p>F-225 Continued on next page...</p>		

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F 225	<p>Continued From page 13</p> <p>was determined the allegation was not abuse/neglect.</p> <p>Interview with the DON at 9:35 AM on 10/13/13 revealed she made the decision not to suspend the alleged perpetrator after Resident #9 made the allegation that the employee squeezed the resident's ribs and hurt his/her leg. The DON stated she did not feel the employee intentionally abused/neglected Resident #9. The DON stated she felt the employee "just" needed more training. According to the DON, Resident #9 had voiced the need for the employee (alleged perpetrator) to receive training on resident transfers because the nurse aide was a newly hired employee. The DON was unable to locate documented evidence that the facility's investigation included interviews with the witnesses and potential witnesses of the alleged incident and the investigation did not include a physical assessment of Resident #9. The allegation was not reported to any state agency.</p> <p>Interview with the Administrator at 2:00 PM on 10/13/13, revealed the allegation was discussed in the IDT meeting and the IDT did not view the allegation as abuse/neglect. As a result of the IDT's decision, the facility did not investigate the incident and did not report the allegation to the state agencies.</p> <p>3. Review of the medical record revealed the facility admitted Resident #1 on 06/14/08, with diagnoses which included Cerebrovascular Accident, Dementia, Hypertension, Aphasia, and Seizure Disorder.</p> <p>Review of a Quarterly Minimum Data Set (MDS) assessment dated 10/03/13, revealed the facility</p>	F 225	<p>F-225 Continued ...</p> <p>In-service/re-education training implementation began for 100% of employees, specifically including Administrator, DON and Social Services Director, immediately on October 10, 2013 by SDN, when the discovery was made and the potential for systemic failure was identified. (See Exhibit #2: Resident Abuse Training Materials F-225/F-226, Abuse Policy revision date 10/10/2013 and attendance records). The in-services, education and policy changes were completed on October 12, 2013 through one on one training with every employee by Staff Development Nurse (See Exhibit # 4: Abuse Training Verification Log). No employee was/will be allowed to work until completion of training (if on Leave or Vacation training with validation of competency will be completed before allowing return).</p> <p>F-225 continued next page ...</p>		

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F 225	<p>Continued From page 14</p> <p>assessed Resident #1's cognition to be severely impaired with a Brief Interview for Mental Status (BIMS) score of 3, indicating the resident was not interviewable.</p> <p>Review of a Grievance/Complaint Report dated 06/05/13, revealed staff reported to the facility's Social Services Director (SSD) they had observed a notation ("you smell like poop") written on Resident #1's adult incontinence brief. Further review of the Grievance/Complaint Form revealed the facility failed to investigate the allegation or obtain any statements from any witnesses.</p> <p>The SSD confirmed in an interview conducted on 10/12/13 at 4:30 PM that first shift staff reported to her they had observed the notation ("you smell like poop") on Resident #1's adult incontinence brief at the beginning of their shift. The SSD stated he/she addressed the alleged complaint in the Interdisciplinary Team (IDT) meeting on the morning of 06/05/13. The SSD stated the IDT determined the allegation was not considered to be a form of abuse/neglect.</p> <p>Interview with the Director of Nursing (DON) at 6:25 PM on 10/12/13 revealed the IDT had determined the notation on Resident #1's brief was not abuse or neglect of Resident #1. The DON stated that based on the resident's impaired cognition, the IDT determined the resident was unaware of the notation written on his/her brief and that the staff member had intended for her co-worker to find the writing on the resident's brief. The DON stated he/she suspended the staff member who had written the note on the resident's brief for one day due to the employee's inappropriate behavior; and the coworker of the employee who wrote the note was given a verbal</p>	F 225	<p>F-225 Continued...</p> <p>4. An Abuse/Complaint assessment tool was developed and implemented on October 11, 2013, (See Exhibit # 1; Abuse/Complaint Assessment Tool). All alert and oriented residents were interviewed by DON, SSD, MDSN, UCN, SDC and MRD for any statements/evidence of suspected abuse, concerns, neglect, exploitation or misappropriation. In order to ensure all violations involving mistreatment, abuse, neglect or misappropriation of resident funds or property are investigated thoroughly through interviews with staff and residents, head to toe physical assessments, record reviews, residents are protected and allegations are reported timely to state agencies, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Nurse (SDC), Social Services Director (SSD), Minimum Data Sets Nurse (MDSN), Unit Coordinator Nurse (UCN), Nurse Supervisor (NS) or designee will audit by utilizing Abuse/Complaint Assessment Tool daily x 1 week, then weekly x 4 weeks, then monthly x 1 month, longer if 100% compliance of process is not achieved. Beginning October 11, 2013. The Assessment Tool will be utilized on weekends as well. The weekend completion will be performed by the NS. If NS is unavailable then the DON, ADON, MDSN or SDC will be responsible to carry out this task.</p> <p>F-225 Continued next page...</p>	

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F 225	<p>Continued From page 15</p> <p>warning for the incident. The DON was unable to locate any written statements from any witnesses or from the two staff members involved in the incident. The DON stated the IDT determined the incident was not abuse and/or neglect because the note was not directed toward the resident and the two employees had already left the facility for the day. The DON acknowledged the facility had not investigated the incident any further and had not reported the incident to the appropriate state agencies.</p> <p>Interview with the Administrator at 2:00 PM on 10/13/13 revealed the IDT determined this allegation was not abuse and/or neglect. Therefore, the Administrator stated the IDT felt no harm had occurred to the resident, and there was no reason to investigate the incident any further or report to the appropriate state agencies.</p> <p>4. Review of the medical record revealed the facility admitted Resident #5 on 11/15/12 with diagnoses that included Bipolar Disorder, Manic, Psychosis, Senile Dementia, and Depression.</p> <p>Review of a Grievance/Complaint Report revealed an allegation of possible abuse was reported by Licensed Practical Nurse #7 to the Social Services Director (SSD) on 04/09/13. According to the report, Resident #5 reported a nurse aide "pushed" him/her in the back when care was provided on 04/09/13. Further review of the investigation revealed a witness statement was obtained from the alleged perpetrator (CNA #12) and Resident #5. In addition, the resident's roommate was also interviewed and reported he/she had not witnessed anything "out of the way." The investigation noted the alleged perpetrator would be moved to another area of</p>	F 225	<p>F-225 continued ...</p> <p>Daily oversight by the Administrator will be provided, including weekends, by discussion and/or reviewing and initialing the audits after review to ensure residents were protected, reporting was timely and the investigations were thorough through interviews with staff and residents, physical head to toe assessments, record reviews. In addition, the Managing Partner will review twice weekly with the Administrator in an informal format to ensure that allegations are reported timely, residents are protected, receive appropriate assessments, perpetrators are suspended or terminated and a thorough investigations are being performed which includes through interviews with staff and residents, head to toe physical assessments and record reviews, any alleged abuse, neglect; misappropriation of funds identified will be investigated in a timely manner to ensure the resident's safety with an assessment for any physical or psychosocial issues. Immediate suspension of staff involved and timely notification of state agencies will be completed immediately, by SSD, DON, ADON, MDSN, SDC, Administrator, NS or UCN.</p> <p>F-225 continued next page...</p>	

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F 225	<p>Continued From page 16</p> <p>the facility to continue working. Continued review of the investigation report revealed no evidence the facility conducted further investigation to include a physical assessment for possible injury to the resident and no evidence the allegation was reported to the state agencies.</p> <p>Review of the Quarterly Minimum Data Set (MDS) assessment dated 08/29/13, revealed the facility assessed Resident #5 to have a Brief Interview for Mental Status (BIMS) score of 11, which indicated the resident was alert and interviewable. Interview conducted with Resident #5 on 10/13/13, at 2:30 PM, revealed he/she could not recall the alleged incident. Resident #5 stated he/she had no problems with staff treatment related to abuse.</p> <p>Interview with LPN #7 conducted on 10/13/13, at 4:25 PM, revealed the alleged perpetrator (CNA #12) reported the incident to her on 04/09/13. LPN #7 stated the nurse aide denied the allegation and was reassigned to another hallway to complete her shift. LPN #7 stated she had been trained to protect the resident and to send the alleged perpetrator home when an allegation of abuse was reported. The LPN stated she notified the SSD of the allegation, but could not recall who directed her to reassign the nurse aide to another area of the building.</p> <p>Interview conducted with the SSD on 10/13/13, at 9:35 AM, revealed she went to the facility on 04/09/13 after Licensed Practical Nurse (LPN) #7 called her at home to report the alleged incident. The SSD stated she immediately initiated an investigation and talked with Resident #5. The SSD stated the alleged perpetrator (CNA #12) had been moved to another hall to work by the</p>	F 225	<p>F-225 continued...</p> <p>The DSS, DON, Administrator, ADON, MDSN or NS will conduct an abuse monitor, (See Exhibit # 7: Village of Lebanon, LLC Abuse Monitor), weekly x 4 weeks, then every month for three months, then quarterly thereafter and report to Quality Assurance Committee for guidance, direction and oversight. In Addition, The DSS, DON, ADON, MDSN or NS will complete an Allegations of abuse, neglect or misappropriations Quality Assurance Log to be reported on a daily basis to the IDT Committee (Morning Meeting) and will be reviewed daily by the Administrator or designee (SDN) and Director of Nursing or designee (ADON/MDSN) for Tracking and trending such as, discovery of any trends in the report, allegations occurring on the a certain shift, day, night, evening, whether or not a certain employee, event or situation had developed a pattern that would require additional investigation such as, interviews with staff and residents, head to toe physical assessments, record reviews. In Addition, The DSS, DON, ADON, MDSN or NS will complete an Allegations of abuse, neglect or misappropriations Quality Assurance Log to be reported on a daily basis to the IDT Committee (Morning Meeting) and will be reviewed daily by the Administrator or designee (SDN) and Director of Nursing or designee (ADON/MDSN) for Tracking and trending such as,</p> <p>F-225 continued next page...</p>	

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F 225	<p>Continued From page 17</p> <p>time she arrived at the facility. The SSD stated she did not obtain a witness statement from LPN #7 when conducting the investigation. In addition, the SSD stated the complaint report was reviewed during the Interdisciplinary Team (IDT) meeting on 04/10/13. According to the SSD, the IDT team concluded the alleged perpetrator was attempting to prevent Resident #5 from falling at the time of the incident, abuse had not occurred, and therefore the allegation was not reported to state agencies and no further investigation was conducted. Further interview revealed the SSD did not inform the Administrator or DON of the allegation.</p> <p>Interview with the DON on 10/13/13, at 10:50 AM, revealed she was not aware of the allegation until the Grievance/Complaint Report was reviewed and discussed during the IDT meeting on 04/10/13. The DON stated she believed LPN #7 had reassigned the alleged perpetrator to another hall to complete the assigned shift at the time the incident was reported. However, according to the DON, after the IDT meeting the alleged perpetrator had been permitted to return to her regular assignment as scheduled and no further disciplinary action was taken. In addition, the DON stated the allegation had not been considered abuse after she reviewed the alleged perpetrator's witness statement and learned the nurse aide was assisting the resident to prevent a fall. The DON further stated the allegation did not meet the facility's criteria for abuse and no further investigation had been conducted. In addition, the DON stated the allegation had not been reported to the appropriate state agencies because the allegation did not meet the criteria for abuse. According to the DON, to meet the facility's criteria for abuse, the abuse would be</p>	F 225	<p>F-225 continued...</p> <p>...discovery of any trends in the report, allegations occurring on the certain shift, day, night, evening, whether or not a certain employee, event or situation had developed a pattern that would require additional investigation. This log will be turned in monthly to the QA committee for review and oversight, (See Exhibit #6: Allegations of Abuse, Neglect, Misappropriations Quality Assurance Log) The Abuse reporting form was revised on October 14, 2013 by the IDT. (See Exhibit # 9: Abuse Reporting/Investigation Worksheet), which will have oversight by Assistant Administrator and/or Administrator on a daily basis with oversight by Medical Director through Monthly Quality Assurance. Quality Assurance/Risk Management Policy was updated October 13, 2013 to include specific oversight of Abuse, Neglect, Misappropriation oversight and input from Medical Director. (See Exhibit # 10: Quality Assurance Policy).</p>	11/01/2013

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F 225	<p>Continued From page 18</p> <p>found substantiated or found to have occurred to meet these criteria.</p> <p>The Administrator stated in interview conducted on 10/13/13, at 1:40 PM, he had been notified regarding the alleged incident with Resident #5. The Administrator stated the allegation had not been reported to state agencies or further investigation conducted because the IDT decided the nurse aide was trying to help Resident #5. The Administrator stated he considered the criteria for abuse would be anything that might "inhibit the health and welfare of the resident."</p> <p>5. Review of the medical record revealed the facility admitted Resident #6 on 08/23/13 with diagnoses that included Subdural Hemorrhage, Alzheimer's Disease, Dementia, Psychosis, Agitation with Behavioral Disturbance, and Cerebrovascular Accident.</p> <p>Review of the Admission Physician's Orders, dated 08/23/13, revealed the physician had prescribed 0.5 milligram (mg) of Risperidone (antipsychotic) to be administered on a daily basis to Resident #6.</p> <p>Review of the Admission Comprehensive MDS assessment dated 08/29/13, revealed the facility assessed Resident #6 to have a short and long-term memory deficit with moderately impaired decision-making skills.</p> <p>Review of the Grievance/Complaint Report dated 08/30/13, revealed on 08/30/13 the resident's family member alleged the resident failed to receive Risperidone as ordered by the physician for the "past few days."</p>	F 225		

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F 225	<p>Continued From page 19</p> <p>Further review of the Grievance/Complaint Report revealed (no date was indicated) Unit Supervisor (US) #2 spoke with the nurse, who administered medications to Resident #6 on 08/29/13, and verified the resident's medications had been given on 08/29/13. However, there was no evidence the facility's investigation covered the allegation to ensure that the resident's medication had been administered as prescribed by the physician in an effort to determine if the allegation was substantiated.</p> <p>Interview conducted with the SSD on 10/12/13, at 6:15 PM, revealed the Grievance/Complaint Report was reviewed in the daily IDT meeting and US #2 was assigned to verify if the resident received the prescribed medications on 08/29/13. The SSD stated she had not realized the allegation was concerning more than that date (08/29/13). As a result, there was no documented evidence the facility's investigation had been completed to ensure Resident #6 had received medications as ordered by the physician. In addition, the SSD stated the allegation had not been reported to the state agencies.</p> <p>The DON stated in interview conducted on 10/13/13, at 10:40 AM, she had not realized the allegation was that Resident #6 had not received the prescribed medications for more than one day (08/29/13). The DON confirmed no further investigation had been conducted and the allegation had not been reported to the state agencies.</p> <p>6. Review of the medical record revealed the facility admitted Resident B on 12/18/09 with diagnoses which included Alzheimer's Disease,</p>	F 225			

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F 225	<p>Continued From page 20</p> <p>Dysphagia, Anxiety, and Stage III Malignant Neoplasm of the Prostate. Review of the Speech Therapist's (ST's) Discharge Summary related to the resident's dysphagia, dated 05/30/13, revealed the resident required close monitoring of meals and bite-size food portions alternated with solids and liquids. The ST further noted the resident required 1:1 assistance with meals to aid with oral clearance. Review of the October 2013 physician's orders for Resident B revealed the resident was to receive a regular puree diet with honey-thickened liquids.</p> <p>Review of the Annual MDS assessment dated 07/11/13, revealed the facility assessed Resident B to have short and long-term memory impairment with severely impaired decision-making skills. In addition, the resident was assessed to require extensive assistance of one staff person for eating/drinking. Review of the Comprehensive Care Plan dated 08/23/13, revealed the facility addressed concerns with Resident B's dysphagia and nutrition. Based on the Care Plan assessment, facility staff developed interventions to assist the resident with meals. The identified interventions included the implementation of a restorative feeding program which included setting up the resident's meal tray, encouraging the resident to feed himself/herself, to feed the resident if needed, to provide cues to chew and swallow foods, and to report any difficulty the resident had with chewing/swallowing.</p> <p>Review of a Grievance/Complaint Report dated 09/25/13, revealed a family member of another resident was in the facility's dining room during the evening meal on 09/24/13. The report revealed the family member reported he/she had</p>	F 225		

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F 225	<p>Continued From page 21</p> <p>observed Resident B choking while being assisted and fed by a nurse aide, while the nurse aide was looking at the television and was unconcerned when the resident began coughing/choking. The report further alleged the nurse aide was rude and wiped the resident's mouth "hard" and jerked the resident's bib off.</p> <p>Further review of the Grievance/Complaint Report revealed the facility had obtained witness statements from the alleged perpetrator (CNA #8), another nurse aide, and the Restorative Nurse. The witness statements revealed the three staff members were aware of the aspiration risks and feeding techniques for Resident B. The witness statements also revealed Resident B coughs easily when eating and had not exhibited signs of choking/aspiration or acute distress during the evening meal on 09/24/13. According to the witness statements, CNA #8, the alleged perpetrator, was not rude or rough with Resident B. However, there was no evidence the facility suspended/removed the alleged perpetrator during the investigation. In addition, there was no evidence the facility's investigation included a physical assessment of Resident B to ensure the resident was not harmed and no evidence the facility reported the allegation to the state agencies.</p> <p>Interview conducted with the DON on 10/13/13, at 11:05 AM, revealed the facility had not removed the alleged perpetrator (CNA #8) from direct care at the time the allegation was reported on 09/25/13. The DON stated she was familiar with Resident B's feeding problems of frequent coughing and aspiration risks and did not feel any abuse had occurred with the resident. The DON stated she believed the family member could</p>	F 225			

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F 225	<p>Continued From page 22</p> <p>have been disturbed and became scared when they observed the resident coughing and food running out of his/her mouth. The DON stated the concern had been discussed in the IDT meeting and it was determined abuse and/or neglect had not occurred, and therefore the allegation was not reported.</p> <p>The Administrator stated in interview conducted on 10/13/13, at 1:40 PM, he believed the report had been discussed during the IDT meeting on 09/25/13. The Administrator stated he was familiar with Resident B's feeding/aspiration risks and that the complainant could have perceived the incident as inappropriate. The Administrator stated he agreed with the decision made by the DON and the IDT team not to remove the alleged perpetrator (CNA #8) from direct care, and the incident did not meet the criteria to report to the state agencies.</p> <p>7. Further review of the Grievance/Complaint Reports revealed eight additional reports related to missing monies had been reported to the facility (Residents #9, #11, D, E, F, and G).</p> <p>On 11/01/12, Resident D reported to the SSD he/she was missing \$4.36. The resident alleged the money had been missing since 10/31/12. On 11/05/12, Resident E reported he/she had \$30.00 missing since 11/04/12. Resident #9 reported \$5.00 was missing on 11/05/12 and Resident #11 reported \$5.00 was missing from his/her chest at the resident's bedside on 11/20/12.</p> <p>Review of the investigation for each of these reports revealed the facility reimbursed the resident for the amount reported missing. However, there was no evidence the facility had</p>	F 225			

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F 225	<p>Continued From page 23</p> <p>reported these incidents to the State agencies and no evidence the facility's investigation included relevant resident interviews and interviews of staff caring for the residents at the time the money was reported missing.</p> <p>Interview conducted with the SSD, Administrator, and DON on 10/13/13, at 3:30 PM, revealed they did not believe either of these allegations met the criteria for misappropriation and did not conduct further investigation or report these incidents to the state agencies. The SSD, Administrator, and DON stated they did identify a trend of repetitive reports of missing monies. In addition, the interviews revealed facility staff had also reported they had monies missing and believed a nurse aide (CNA #11) was responsible. According to the SSD, Administrator, and DON, they contacted the local police and "planted" money on 11/27/12 in an attempt to determine if CNA #11 was taking monies from residents and/or staff. The SSD, Administrator, and DON stated CNA #11 was terminated on 11/28/12 after it was determined he/she had taken the money that had been "planted" by the facility. The SSD, Administrator, and the DON stated as a result of the facility's findings they determined the allegations of missing resident monies were substantiated and that the problem been resolved when they terminated CNA #11's employment at the facility.</p> <p>*An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy was received on 10/22/13, which alleged the Immediate Jeopardy was removed on 10/22/13.</p> <p>Review of the AOC revealed a complete anatomical assessment was conducted by the DON, Nursing Supervisor (NS), MDS Nurse, and</p>	F 225			

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F 225	<p>Continued From page 24</p> <p>Unit Coordinator (UC) for signs or symptoms of abuse for all in-house residents utilizing a newly implemented Abuse/Complaint Assessment Tool on 10/11/13. In addition, all alert and oriented residents as well as staff were interviewed by the DON, SSD, MDS Nurse, UC, Staff Development Coordinator (SDC), and Medical Records Director (MRD) to ensure no evidence of suspected abuse, neglect, exploitation, or misappropriation had not been reported. The AOC stated all past reports of abuse and grievances for the past year were reported to the state agencies and an investigation was initiated to investigate the eight (8) allegations related to abuse/neglect as well as the protection of the resident during the investigation.</p> <p>The AOC revealed the facility's Abuse Policy was reviewed and updated in accordance with the State Operations Manual (F225 and F226) on 10/10/13. In-service training was initiated on 10/10/13 and completed on 10/12/13, for 100 percent of facility employees by the Staff Development Coordinator (SDC).</p> <p>The AOC further revealed the Administrative staff, including the Administrator, DON, and SSD, was counseled by the Corporate Officer and retrained by the Staff Development Nurse on 10/10/13 on the Abuse policy.</p> <p>Further review of the AOC revealed the facility would ensure continued compliance through the completion of a daily Continuous Quality Improvement (CQI) form to be reviewed during the daily CQI meeting to ensure all concerns/grievances have been thoroughly reviewed and all issues have been addressed per policy with appropriate reporting to the state</p>	F 225		

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F 225	<p>Continued From page 25</p> <p>agencies. The CQI form will be reviewed daily by the Administrator and bi-weekly by the Managing Partner. In addition, the AOC noted an Abuse Log would be completed daily by the SSD, DON, ADON, MDS Nurse, or NS and reviewed daily by the Administrator, DON, or designee. The Administrator would provide daily oversight to ensure all allegations of abuse, neglect, misappropriation of property identified will be investigated in a timely manner, involved staff was immediately suspended, and state agencies were notified immediately. The AOC further indicated the Allegations of Abuse Log would be utilized to track/trend reported allegations and would be reviewed monthly with the QA Committee.</p> <p>**The surveyors validated the corrective action taken by the facility as follows:</p> <p>Review of the facility's documentation revealed a one hundred percent (100%) audit had been conducted of all in-house residents on 10/11/13 by the DON to identify any potential signs or indicators of abuse, neglect, or misappropriation. A review of the daily census for 10/11/13, verified all residents had been assessed for abuse, neglect, and misappropriation. Review of the Abuse/Complaint question assessment tool and interviews conducted with residents and facility staff revealed no signs or symptoms of abuse were evident. A review of the facility's investigations revealed the facility had reopened the allegations identified in the AOC and had conducted an investigation which included suspension/termination of the alleged perpetrators and appropriate reporting of each allegation immediately to the state agencies. Interview conducted with the DON on 10/23/13,</p>	F 225			

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F 225	<p>Continued From page 26</p> <p>revealed the investigations had been reopened and witness interviews and other pertinent data had been used to determine if the allegation was substantiated or unsubstantiated. The DON also provided evidence that protection had been provided for the residents during the investigation and the allegations had been reported to the state agencies as indicated in the AOC.</p> <p>Review of the facility's Abuse policy revealed the policy had been revised to reflect interventions to be utilized to deal with reporting, protection, and investigation of all allegations of abuse. A review of the facility's in-service sign-in sheets, pre/post tests, and interviews with staff (RN #1, LPN #10, LPN #11, CNAs #13, #14, #15, and #16, Housekeeping Staff Members #1 and #2 and Dietary Staff Member #1) on 10/23/13, verified staff had been in-serviced on 10/10/13, 10/11/13, 10/12/13, 10/14/13, 10/15/13, 10/17/13, 10/19/13, and 10/21/13, as stated in the AOC. Staff further revealed they had been in-serviced on the revised/updated abuse policy to include timely reporting of any allegation of abuse/neglect by the use of a pre/post test. The revised abuse policy material included educating staff on how to identify, assess, complete thorough investigations, and timely reporting.</p> <p>Review of the Performance Improvement Forms dated 10/10/13 verified counseling was provided for the Administrator, DON, and the SSD by the Corporate Officer. In addition, review of the in-service records dated 10/11/13 revealed retraining related to the Abuse policy was provided to the Administrator, DON, and the SSD on 10/11/13. Interviews conducted with the Administrator, DON, and the SSD on 10/23/13 confirmed counseling and reeducation had been</p>	F 225			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____		(X3) DATE SURVEY COMPLETED 10/23/2013
NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033		
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F 225	Continued From page 27 provided as stated in the AOC. Interviews conducted with members of the IDT team (Administrator, SSD, DON, UC, Dietary Manager, Activities Director, SDC, and MDS Nurse) on 10/23/13, revealed the allegations of abuse, neglect, exploitation, and misappropriation were reviewed daily during the IDT meeting to ensure the allegations/concerns were appropriately reported, investigated, and resident protection provided. Review of the Abuse/Complaint question assessment tool and interviews conducted with Residents #3, I, J, K, L, and M on 10/23/13, verified staff had interviewed them daily from 10/11/13 to 10/18/13 to determine if any abuse had occurred. Further review of the abuse/complaint questionnaire revealed the Administrator, DON, and Managing Partner reviewed the information daily. Interview conducted with the Administrator on 10/23/13, at 5:45 PM, revealed he reviewed the Abuse Log daily and any identified discrepancies were corrected immediately to ensure all allegations of abuse, neglect, or misappropriation were investigated and reported, and protection for residents was provided appropriately. The Administrator stated the Abuse log would be utilized as a tracking/trending tool to report any trends and problems to the QA Committee.	F 225			
F 226 SS=J	483.13(c) DEVELOP/IMPLMENT ABUSE/NEGLECT, ETC POLICIES The facility must develop and implement written policies and procedures that prohibit mistreatment, neglect, and abuse of residents and misappropriation of resident property.	F 226	F 226 1. Residents identified as being affected were physically assessed immediately for any signs or symptoms of abuse by the DON. There were no signs or symptoms of abuse revealed. Their cases were re opened. The residents were immediately protected, and investigations were performed as follows: F-226- Continued next page...		

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F 226	Continued From page 28 This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policy and procedures and facility investigations, it was determined the facility failed to develop and implement written policies and procedures that prohibit abuse, neglect, exploitation, and misappropriation of resident personal property for five of fifteen sampled residents (Residents #1, #5, #6, #7, and #9) and one of three unsampled residents (Resident B). The facility's policy did not consistently include the protection component for neglect and abuse, and gave no clear guidance on how to protect residents when an allegation of abuse was reported. Review of the facility's 185 Grievance/Complaint Reports since the last standard survey conducted on 09/11/12, revealed at least 8 of these reports were allegations of abuse/neglect and 8 were allegations of misappropriation of resident property. However, the facility failed to implement policies/procedures to ensure all allegations of abuse, neglect, exploitation, and misappropriation were reported immediately and failed to ensure residents were protected following a report of abuse and during the investigation process after Resident #7 alleged a nurse aide was rough with him/her during care and "jerked" his/her arm and leg on 09/25/13. In addition, Resident #7 also reported a night shift aide was "mean" to him/her on 09/11/13. Six additional reports of alleged abuse, neglect, and exploitation were identified: Resident #9 reported staff refused to toilet him/her timely and reported he/she was	F 226	F 226 Continued... RSD #1 Allegation: Mental Abuse, Re-opened date: 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: (RSD #1) had inappropriate comments written on brief; (employee) was suspended by DON. An investigation was completed by the use of interviews with staff working at the time of incident as well as residents residing on the same unit. A head to toe assessment was completed on this resident by the DON, there were no bruising, skin tears or other evidence of injury found. Conclusion: It was found through interviews with staff, revealed the message written on the brief was not intended for the resident. It was intended for another employee in a playful manner that would be checking the residents brief on next round. Unsubstantiated and re-educated (was placed on Follow-up Nursing/Facility Staff Performance Program, in which an a staff member is given specific goals related identified issues or potential issues to be reached and maintained throughout the program and is monitored daily while at work by Direct Nursing Staff and Supervisors and meets weekly with DON or ADON for one month for any reoccurrences of complaints or infractions and quality of care being rendered) (See Exhibit #11, Follow-up Nursing/Facility Staff Performance Program Policy and Form) F 226 Continued next page.....		

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F 226	<p>Continued From page 29</p> <p>"squeezed" when being transferred by facility staff, staff reported inappropriate markings were discovered on Resident #1's brief, Resident #5 alleged staff "pushed" him/her in the back, failure to administer medications as ordered was reported involving Resident #6, and staff failed to provide appropriate care during meal time involving Resident B. The facility failed to ensure their investigations included witness and potential witness interviews, resident assessments, and record reviews as indicated. In addition, the facility failed to ensure policies and procedures were implemented to ensure eight allegations of residents' missing money (Residents #9, #11, D, E, F, and G) were reported to the state agencies; and ensure investigations included interviews with residents and staff working with the residents at the time the money was reported missing were also interviewed. (Refer to F225.)</p> <p>The facility's failure to have an effective system in place to ensure the development and implementation of policies and procedures to protect residents from abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy was identified on 10/11/13. The Immediate Jeopardy with Substandard Quality of Care was determined to exist on 09/25/13 at 42 CFR 483.13 Resident Behavior and Facility Practices. The facility was notified of the Immediate Jeopardy on 10/11/13.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 10/22/13, which alleged removal of Immediate Jeopardy on 10/22/13. The state agency determined the Immediate Jeopardy was removed on 10/22/13, which lowered the scope and severity to "D" while the facility monitors the</p>	F 226	<p>F 226 Continued....</p> <p>RSD #5 Allegation: Physical Abuse, Re-opened date: 10/13/13, Date reported 10/13/13, completed Date: 10/17/13; RSD #5 states that (SRNA) pushed her, RSD protected, an investigation was conducted by use of interviews with SRNA and (Resident #5) as well as interviews with other staff and residents on the same unit. A head to toe assessment was performed on RSD #5 that revealed no signs or symptoms of abuse were present, including but not limited to bruising, or skin tears. Conclusion: Resident is care planned for non compliance of care; this includes the use of Medical Bi PAP Machine. A determination was made that SRNA (employee) assisted RSD #5 down in the wheelchair to keep her from falling. The resident was exhibiting signs of extreme confusion and lethargy secondary to refusal to wear a Bi Pap Machine, potentially causing her carbon dioxide levels to be increased, causing RSD #5 to exhibit signs of confusion, sleepiness, and to be slow moving. SRNA stated that she felt RSD #5 was going to fall over her bedside table so she (SRNA) sat her in the wheelchair to keep her from falling. SRNA is no longer employed with the facility. This was on going and completed on October 17, 2013. OIG, APS were notified.</p> <p>F 226 Continued next page...</p>		

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F 226	Continued From page 30 effectiveness of systemic changes and quality. The findings include: Review of the facility's policy, "Abuse," (revised 01/23/13) revealed facility staff was to immediately report any incident of observed abuse, neglect, or misappropriation of resident property to the Charge Nurse. The policy directed that the following steps were to be followed: Remove the resident from an unsafe situation; if an employee was suspected of abuse he/she would be sent home pending an investigation; the Charge Nurse would immediately report the allegation to the facility's Social Services Director (SSD), Administrator, and the Director of Nursing (DON); the resident would then be examined by the Charge Nurse with a head to toe assessment completed; the SSD and DON would immediately initiate an "Abuse Incident Report" and start the investigation; the SSD would immediately notify the Department for Community Based Services (DCBS) and the Office of Inspector General (OIG); and the SSD would collect all information and documentation of the alleged abuse and fax to DCBS and OIG within five working days after receipt of the allegation. Further review of the Abuse policy revealed the involved staff member would be reassigned or suspended, at the discretion of the Director of Nursing or Administrator. 1a. Review of the facility's Grievance/Complaint Report, dated 09/25/13, revealed Resident #7 had reported to Licensed Practical Nurse (LPN) #2 that a Certified Nursing Assistant (CNA) was "rough," "jerking" his/her "arm and leg" the previous night when she was providing the	F 226	F 226 Continued... RSD #6 Re-opened date: 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: Resident family stated RSD #6 did not receive his 1400 dose of Risperadol. An immediate head to toe assessment was completed; a thorough investigation was performed by interviewing all the nurses that had provided care to this resident and dispensed medications from the residents cart, a complete count of the Risperadol was performed. The count of the drug was correct, the MAR revealed that the Risperadol was given and signed out on the MAR. An interview with the RN revealed that the medication was given per physician orders. The resident had not had an increase in behaviors or agitation. RSD #7 The complaint was re-opened on: 10/13/13, Date reported to OIG and APS was 10/13/13, completed Date: 10/17/13: RSD #7 alleged that an aide was rough with care, In an interview with the roommate and resident it was discovered that CNA #4 instructed them (Residents) not to ring the call light as well. (This complaint was re-opened October 21, 2013. An investigation was completed with interviews of residents and staff) the CNA #4 (employee) was suspended by DON an investigation was completed, as well as, a physical assessment of resident was performed by DON and no injuries were noted such as bruising, skin tears, abrasions etc. Conclusion: Statements were taken from other residents and employees. F-226 Continued next page...		

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F 226	<p>Continued From page 31</p> <p>resident's evening care. Further review of the report revealed Resident #7 could not identify the CNA; however, after the resident provided a description of the CNA, the facility identified her as CNA #4. According to documentation on the Grievance/Complaint Report, the facility did not remove CNA #4 from direct care during the course of the investigation to ensure residents of the facility, including Resident #7, were protected from further potential harm during the course of the investigation, failed to conduct a physical assessment of Resident #7 after the allegation was reported, and failed to report the resident's complaint to the appropriate state agencies, as per policy.</p> <p>An interview with Resident #7 on 10/12/13, at 6:30 PM, revealed a night shift CNA had been "very rough" with him/her "jerking" his/her "arm and leg" when the CNA assisted the resident with changing clothing and to bed. Although Resident #7 was unable to identify the CNA by name, the resident stated he/she gave a description of the CNA to facility staff.</p> <p>Interview with CNA #4 on 10/12/13, at 2:30 PM, revealed she had worked the night shift on 09/24/13 and had provided care for Resident #7. CNA #4 stated she was in a hurry and felt Resident #7 thought he/she was going to fall during care while using the "Hoyer" lift (mechanical lift). CNA #4 assured the resident that she wouldn't let him/her fall. According to CNA #4, she was never informed by the facility's DON or Administrator that there had been an allegation of abuse against her and the facility had never suspended her from direct care with the residents.</p>	F 226	<p>F-226 Continued...</p> <p>Upon further questioning of other residents, one other resident voiced complaint related to the roughness in care provided by CNA #4 and Resident #7. The complaint from Resident #7 was investigated thoroughly, reported in a timely manner additional questioning of resident #7 she states that CNA #4 was only rough with her that one time stating that she was in a hurry to put my night gown on, rsd #7 states that employee has never been rough with her before and has not been rough since then. Rsd #7 states that she really likes the CNA #4 and does not mind that she takes care of her. Additional questioning took place with the roommate; she states that CNA #4 pulled rsd #7's crippled leg and that rsd #7 told her about it, roommate states that SRNA immediately apologized stating that she did not mean to pull her leg. Roommate states that SRNA has never been rough with her and she has never seen her be rough with any other resident, and that she likes SRNA. SRNA instructed those (Residents) not to ring the call light as well. (This complaint was re-opened October 21, 2013. A thorough investigation was completed with interviews of residents and staff). Upon further investigation with (Resident #7) it was determined that (Employee) stated "Do not put the call light on". RSD #7 also stated that she was unsure as to why (Employee) made that statement. Upon interviewing roommate she stated that (Employee) stated "Don't put your call light on" roommate stated that CNA #4 stated this as she was leaving the room both residents is unsure as to why the statement was made by (Employee).</p> <p>F-226 Continued next page...</p>		

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F 226	<p>Continued From page 32</p> <p>The SSD confirmed in interview on 10/12/13, at 4:10 PM, that the DON was notified on 09/25/13 (time unknown) of the complaint made by Resident #7 on 09/25/13. The SSD stated the DON had asked the SSD to obtain a written statement from CNA #7 and she would make a decision after she had obtained and reviewed the CNA's statement. According to the SSD, she considered the complaint voiced by Resident #7 as an allegation of abuse and stated, "I felt I should have called it in but I don't have the authority. It has always been the Administration's final decision to call it in."</p> <p>An interview with the DON on 10/12/13, at 2:45 PM, revealed that she was notified of the allegation regarding Resident #7 that occurred on 09/25/13 but was unsure of the time she was notified. She went on to say that she didn't report the allegation because she "felt like it was more of a complaint" and "didn't feel like it was an allegation of abuse." The DON said that she was going to suspend CNA #7 for one day but CNA #7 called in the next day (09/26/13) and upon CNA #7's return to work she was allowed to work on 09/27/13. The DON said the one-day suspension would have been for using the Hoyer lift without two CNAs.</p> <p>During the interview with the Administrator on 10/12/13, at 2:40 PM, he revealed he was made aware of the allegation, dated 09/25/13, in the Interdisciplinary Team (IDT) meeting. The facility Interdisciplinary Team (IDT) consisted of the following staff: Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Nurse, Social Services Director, Minimum Data Set Nurse, Director of Finance, Medical Records Director, Managing Partner, Director of Dietary,</p>	F 226	<p>F-226 Continued...</p> <p>Staff that worked with CNA #4 was interviewed to determine if they knew that CNA #4 would tell residents not to put on the call light. Staff statements reflect that they had never witnessed CNA #4 speaking in that manner to any resident or asking them not to put on their call lights. Interviews with other residents revealed that they had never been told to not put on their call lights by CNA #4. It was determined that CNA #4 had established a pattern of complaints and review of past counseling's related to not following care plans, such as resident to be transferred by two person assist with the use of Hoyer lift, it was determined that the potential for abuse and neglect was present if she remained in the facility. A proactive approach was taken in this allegation to terminate the employee preventing any potential abuse, neglect, exploitation or misappropriation from this individual in the future, (Substantiated, Employee Terminated 10/21/2013).</p> <p>RSD #9 Complaint reopened, 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: (RSD #9) states that (employee) refused to take her to the bathroom, employee was suspended and a thorough investigation was completed. Conclusion: Additional investigation revealed that (Employee) did not refuse to take resident to the toilet as evident by interviews with staff members that were present at the time and residents roommate and residents that lived on the same unit as RSD #9.</p> <p>F-226 Continued next page...</p>		

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F 226	Continued From page 33 Housekeeping Director, Director of Maintenance, Unit Coordinator Nurse, Nurse Supervisor, and Restorative Program Nurse. After the IDT reviewed the report, they (IDT) felt it was a complaint and "no abuse occurred." "Maybe we shouldn't have thought that." The Administrator stated, "I felt it (policy) would have been followed. Was it? No. I felt like it was followed related to the IDT meeting." The Administrator said the IDT had decided not to report this allegation to the state agencies. 1b. Review of a facility Grievance/Complaint Report dated 09/11/13, revealed Resident #7 reported on 09/11/13, that a CNA on the night shift was mean to him/her and had complained to the resident that he/she was using the call bell "every two to three minutes." Continued review of the report revealed Resident #7 had also reported staff had not placed his/her leg on a pillow and didn't administer his/her pain medications when requested. According to the report, Resident #7's roommate was interviewed and revealed that the CNA "jumped" onto them for "ringing the call bell." Documentation revealed Resident #7 and his/her roommate were unable to identify the CNA. Review of the Grievance/Complaint Report revealed the SSD obtained statements from Resident #7, the resident's roommate, and staff members that had worked on the night shift on the hall of Resident #7. The report revealed the SSD had also interviewed other residents on the same hall as Resident #7 on the night of 09/10/13 and based on documentation, the residents did not report concerns related to resident care, abuse and/or neglect, or not receiving medications timely. Further review of the Grievance/Complaint Report revealed there was no evidence the resident's	F 226	F-226 Continued... Present if she remained in the facility utilizing revised abuse policy. A proactive approach was taken in this allegation to terminate the employee preventing any potential abuse, neglect, exploitation or misappropriation from this individual in the future, (Substantiated, Employee Terminated 10/21/2013). RSD #9: Complaint reopened, 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: SRNA was suspended by DON and an investigation was conducted which included interviews with Staff that were present and residents on the same unit. A physical assessment was conducted, that revealed no bruising, skin tears or any other signs of abuse. Conclusion: Determination made that accused SRNA did not squeeze (Resident) after interview with SRNA and (Resident). (Resident) stated that she simply did not like the way she was transferred that time. Noted, (Resident) has diagnosis of severe rheumatoid arthritis and continuous generalized pain of entire body. In addition to: Obsessive Compulsive Disorder, Depression and Anxiety requiring mild and soft transfers. Allegation was unsubstantiated; SRNA was re-educated on proper transferring techniques with this resident). F-226 Continued next page...		

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F 226	<p>Continued From page 34</p> <p>complaint had been reported to the appropriate state agencies.</p> <p>Interview with Resident #7 on 10/13/13, at 10:58 AM, revealed that he/she couldn't recall much information regarding the allegation that occurred on 09/10/13. Resident #7 did state that he/she recalled that a CNA on the night shift had asked him/her if he/she thought "it's funny ringing the call bell all night."</p> <p>Interview with the SSD on 10/13/13, at 10:05 AM, revealed she received a complaint on 09/11/13 from Resident #7 that on 09/10/13 a night shift aide had been mean to her, and the SSD had initiated a Grievance/Complaint Report on 09/11/13. According to the SSD, she obtained a statement from Resident #7 related to the incident that occurred on 09/10/13, on the night shift. The resident alleged a CNA on the night shift was mean to him/her, had not placed the resident's leg on a pillow, had not administered the resident's pain medications when requested, and complained that he/she was ringing his/her call bell every two to three minutes. The SSD also stated she reported the allegation to the DON on 09/11/13. The SSD stated in gathering information for the report she obtained statements from six additional residents on the same hall as Resident #7 and they had not voiced any concerns related to abuse, neglect, or not receiving their medications on time on the evening of 09/10/13. The SSD stated as a result of the interviews with Resident #7, and the six additional residents, she did not think abuse had occurred and the allegation was not reported to the appropriate state agency.</p> <p>Interview with the DON on 10/12/13, at 1:00 PM,</p>	F 226	<p>F-226 Continued...</p> <p>SRNA was able to demonstrate how transfer took place with RSD #9 and was directed on how to better transfer with this resident by the DON. Rsd with diagnosis of severe rheumatoid arthritis and continuous generalized pain of entire body. In addition to: Obsessive Compulsive Disorder, Depression and Anxiety RSD #9, as related to her diagnosis of Obsessive Compulsive Disorder requests to be toileted every 15-30 minutes. She was placed on a Bowel and Bladder Plan by her Physician with interventions including; toilet every 2 hours at specific times. (Employee) was following the plan of care set forth by the Physician, and encouraging RSD #9 to wait until the set time to go. The bowel and bladder plan has been care planned and discussed many times with RSD #9. She is in agreement with the plan. She still continues to ask to go the toilet every 15-30 minutes. Staff continues to re-educate her on a daily basis as to her planned program set forth by her physician. Note: (Resident) has been on the scheduled Bowel and Bladder Program since 1/18/2013. The Allegation was Unsubstantiated, (Employee) was re-educated as to (Resident) specific Bowel and Bladder Program and proper toileting techniques.</p> <p>F-226 Continued next page...</p>		

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F 226	<p>Continued From page 35</p> <p>revealed she had reviewed Resident #7's Medication Administration Records (MARs) for the evening of 09/10/13 and determined the resident had received his/her pain medications. The DON also stated she spoke with all staff that had provided direct care to Resident #7 on 09/10/13 and determined staff had answered Resident #7's call light in a timely manner, met the resident's care needs, and had administered pain medications to the resident as requested. The DON stated the resident had not sustained any injuries and she "didn't feel like it was abuse."</p> <p>Interview with the Administrator on 10/12/13, at 2:58 PM, regarding the Grievance/Complaint Report on 09/11/13, revealed he was probably made aware of the allegation in the IDT meeting but was unable to recall the date. The Administrator stated, "I feel care was provided" and "felt like the policy was followed related to the IDT meeting."</p> <p>2a. Review of a Grievance/Complaint Report revealed the Social Services Director (SSD) initiated a report on 06/13/13 based on a report by Resident #9 that "a big guy" on the night shift refused to take the resident to the bathroom. The Report revealed the resident reported the "guy" said he would return to take him/her to the bathroom, but never returned. Based on the report, the facility identified the employee as CNA #6. Continued review of the report revealed the facility did not remove the employee from direct care during the facility's investigation of the resident's complaint and the employee was allowed to return to work the following night on 06/14/13. During the facility's investigation, they failed to interview residents and staff and did not assess Resident #9. The facility failed to report</p>	F 226	<p>F-226 Continued...</p> <p>RSD "B"</p> <p>Employee was suspended immediately and an investigation was completed by interviewing staff that were present during meal time as well as other residents that were present. A physical assessment was completed and no adverse affects were noted, lungs were clear, afebrile, vital signs were normal and resident was in no distress. Conclusion: RSD has worked with Speech Therapy and has had a five (5) modified Barium Swallow studies from 6/2012 to 5/2013. The physician is aware and has declined the use of a feeding tube. The RSD is care planned for choking and coughing episodes during meals. Staff is educated to stop feeding and allow him to "Cough and Clear" while being monitored by the feeding staff during these episodes. Unsubstantiated and re-educated as to proper feeding techniques and the potential for this resident to aspirate during feeding and when to alert nursing staff to potential aspiration.</p> <p>F-226 Continued next page...</p>		

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F 226	<p>Continued From page 36</p> <p>the resident's complaint of neglect to the appropriate state agencies, and failed to ensure residents were protected from further neglect during the facility's investigation of the resident's complaint, as per policy.</p> <p>Interview with Resident #9 at 9:45 PM on 10/13/13 revealed a "big guy" told the resident he/she would have to wait "30 minutes" before he could take him/her to the bathroom. The resident stated it was difficult to hold his/her "water" while having to wait to be taken to the bathroom.</p> <p>Interview with the SSD at 11:00 AM on 10/13/13 revealed staff reported to her Resident #9 complained that a "big guy" on night shift refused to take him/her to the bathroom. According to the SSD, the allegation was discussed in the IDT morning meeting, and it was determined abuse/neglect had not occurred, and the allegation was not reported to the appropriate state agencies. The SSD stated the facility had identified the employee as CNA #6.</p> <p>Interview with the Director of Nursing (DON) at 1:20 PM on 10/13/13 revealed Resident #9's complaint was discussed in the IDT morning meeting. The DON stated the IDT determined Resident #9 had not been abused and/or neglected due to a written statement from the alleged perpetrator (CNA #6). The CNA stated he did not refuse to take Resident #9 to the bathroom. The IDT determined there was no reason to remove the employee from direct care, to investigate the allegation any further, or to report the resident's complaint to the state agencies.</p> <p>Interview with the Administrator at 2:00 PM on</p>	F 226	<p>F-226 Continued...</p> <p>The facility replaced Residents Monies missing for the following residents #9, #11, D, E, F, and G when incident occurred. Employees were interviewed by the Director of Social Services, to determine events surrounding the missing monies. Residents that live on the same units aside from the RSDs listed above were interviewed. Residents were also interviewed at the time the monies went missing and there was no evidence found to imply that impropriety had occurred other than the disappearance of monies without reason or trace, the facility had replaced the monies. The policy of the facility is that residents are encouraged not to keep money on their person and to have the business office keep their money in the safe and they could get it at any time during the week or weekend. RSD #9 reported \$5.00 was missing on 11/05/12 interviews of staff and other residents did not reveal any information, money was replaced by facility, no evidence of anyone haven it taken was determined. Resident #11 reported \$5.00 was missing from his/her chest at the resident's bedside on 11/20/12, interviews with staff and other residents did not reveal any information, money was replaced by facility, no evidence of anyone haven it taken was determined. On 11/01/12, Resident D reported to the SSD he/she was missing \$4.36, interviews with staff and other residents on the unit did not reveal any information, money was replaced by facility, no evidence of anyone haven it taken was determined. Resident E reported he/she had \$30.00 missing since 11/04/12, interviews with staff and other residents on the unit did not reveal any information. , money was replaced by facility, no evidence of anyone haven it taken was determined.</p> <p>F 226 Continued next page.....</p>		

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F 226	<p>Continued From page 37</p> <p>10/13/13 revealed the complaint voiced by Resident #9 was discussed in the IDT morning meeting and a decision was made that the resident's complaint was not a reportable incident. The Administrator stated he felt the facility was following the abuse policy.</p> <p>2b. Continued review of the facility's Grievance/Complaint Reports revealed the SSD had also initiated a report dated 06/05/13 that on the second shift on 06/05/13 Resident #9 reported a staff member transferred him/her from the wheelchair to the commode "by herself," squeezed the resident's ribs, and hurt his/her leg.</p> <p>Resident #9 stated in interview at 9:45 AM on 10/13/13, "the girl" did not mean to hurt him/her. The resident stated it was "the girl's" first time caring for him/her, and the resident stated he/she felt the employee "just needed more training" prior to caring for him/her.</p> <p>Interview with the SSD at 5:50 PM on 10/12/13, revealed staff reported to her on 06/05/13 that Resident #9 complained "a big girl" on the second shift on 06/04/13, had transferred the resident by herself, squeezed the resident's ribs, and hurt his/her leg. The SSD stated after she interviewed the resident and discussed the resident's complaint with the IDT, it was determined the resident's complaint was not a report of abuse and/or neglect and the facility would not investigate the complaint. The SSD stated the facility had identified the employee as CNA #7.</p> <p>Interview with the DON at 9:35 AM on 10/13/13 revealed she made the decision not to suspend the alleged perpetrator because she did not feel the employee intentionally hurt Resident #9. The</p>	F 226	<p>F 226 Continued</p> <p>2. The facility through interviews with <u>all</u> residents by DON, MDSN and ADON and physical assessments performed by DON on <u>all</u> residents in the facility. There were five <u>(5) allegations of abuse</u> (1. Rough care in the past, 2. fearful of nurse, 3. RSD-RSD doesn't treat me with respect 4. Fearful of minister 5. Rough care provided), <u>six (6) Misappropriations</u> (1. Missing watch 2. Missing necklace 3. Missing blanket 4. Missing clothes 5. Picture taken from room 6. Missing shirt), <u>Two (2) neglect allegations</u> (1. SRNA refused to take rsd to bathroom, 2. RSD states did not receive shower), issues that was determined to exist. Each resident was protected, any potential perpetrators were removed from the resident care area, each resident was physically assessed from head to toe immediately, all appropriate state agencies were notified immediately and each case was investigated by use of interviews with staff, Residents, family members and other persons as needed.</p> <p>F-226 Continued next page...</p>		

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F 226	<p>Continued From page 38</p> <p>DON stated she felt the employee needed more training and no further investigation was conducted into the alleged incident. The DON reported the employee was allowed to work her scheduled shift on 06/05/13. In addition, the DON stated the resident's complaint was not reported to the state agency.</p> <p>Interview with the Administrator at 2:00 PM on 10/13/13 revealed the complaint made by Resident #9 on 06/05/13 was discussed in the IDT meeting, and the IDT did not view the resident's complaint as abuse and/or neglect and as a result, did not remove the CNA from providing direct care. In addition, the Administrator stated as a result of the IDT's decision, the facility did not investigate the resident's complaint further, and did not report the allegation to the appropriate state agencies.</p> <p>3. Review of the facility's Grievance/Complaint Report dated 06/05/13, initiated by the SSD on 06/05/13 revealed staff reported they had observed a notation ("you smell like poop") written on Resident #1's adult incontinence brief.</p> <p>Interview with the SSD at 4:30 PM on 10/12/13 revealed staff had reported to her they had observed the notation ("you smell like poop") on Resident #1's adult incontinence brief at the beginning of the first shift on 06/05/13. The SSD stated the incident was discussed in the IDT meeting on the morning of 06/05/13 and the IDT determined Resident #1 had not been abused and/or neglected as a result of the incident.</p> <p>Interview with the Director of Nursing (DON) at 6:25 PM on 10/12/13 revealed the IDT had determined the notation on Resident #1's brief</p>	F 226	<p>F-226 Continued...</p> <p>3. Systemic changes such as; Quality Assurance/Risk Management Policy and Facility Abuse Policy were updated October 13, 2013 and October 10, 2013 to include specific oversight of Abuse, Neglect, Misappropriation oversight and input from Medical Director. (See Exhibit # 10: Quality Assurance Policy). In-service/re-education training implementation began for 100% of employees, specifically including Administrator, DON and Social Services Director, immediately on October 10, 2013 by SDN, when the discovery was made and the potential for systemic failure was identified. (See Exhibit #2: Resident Abuse Training Materials F-225/F-226, Abuse Policy revision date 10/10/2013 and attendance records). The in-services, education and policy changes were completed on October 12, 2013 through one on one training with every employee by Staff Development Nurse (See Exhibit # 4: Abuse Training Verification Log).</p> <p>F-226 Continued on next page...</p>		

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F 226	<p>Continued From page 39</p> <p>was not considered abuse or neglect of the resident based on the resident's impaired cognition and the inability to determine if the resident had suffered harm. The DON stated the IDT decided there was no need for further investigation and the facility did not report the incident to the state agencies as specified in the facility's policy and procedures. The DON felt the facility's abuse policy was being followed.</p> <p>Interview with the Administrator at 2:00 PM on 10/13/13, revealed the IDT determined this allegation was not abuse and/or neglect. Therefore, the Administrator stated the IDT felt no harm had occurred to the resident, and there was no reason to investigate the incident any further or report to the appropriate state agencies.</p> <p>4. Review of the facility's Grievance/Complaint Report revealed Licensed Practical Nurse (LPN) #7 reported an allegation of possible abuse to the facility's Social Services Director (SSD) on 04/09/13. According to the report, Resident #5 reported a nurse aide "pushed" him/her in the back when care was provided on 04/09/13. The investigation consisted of witness statements obtained from the alleged perpetrator (CNA #12) and Resident #5. In addition, the resident's roommate was also interviewed and reported he/she had not witnessed anything "out of the way." Further review of the investigation revealed the alleged perpetrator (CNA #12) would be moved to another area of the facility to continue working his/her shift. The facility failed to provide evidence that resident protection was provided during the investigation, failed to report the allegation according to the facility's policy, and failed to interview other residents and staff; and did not do a physical assessment of Resident #5</p>	F 226	<p>F-226 Continued ...</p> <p>No employee was allowed to work until completion of training (If on Leave or Vacation training with validation of competency will be completed before allowing return).</p> <p>4. The development of an Abuse/Complaint Assessment tool and the implementation on October 11, 2013, (See Exhibit # 1; Abuse/Complaint Assessment Tool). All alert and oriented residents were interviewed by DON, SSD, MDSN, UCN, SDC and MRD for any statements/evidence of suspected abuse, concerns, neglect, exploitation or misappropriation. In order to ensure all violations involving mistreatment, abuse, neglect or misappropriation of resident funds or property are, investigated thoroughly through interviews with staff and residents, head to toe physical assessments, record reviews, residents are protected and allegations are reported timely to state agencies, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Nurse(SDC), Social Services Director(SSD), Minimum Data Sets Nurse(MDSN), Unit Coordinator Nurse (UCN), Nurse Supervisor(NS) or designee will audit by utilizing Abuse/Complaint Assessment Tool daily x 1 week, then weekly x 4 weeks, then monthly x 1 month, longer if 100% compliance of process is not achieved. Beginning October 11, 2013. The Assessment Tool will be utilized on weekends as well. The weekend completion will be performed by the NS. If NS is unavailable then the DON, ADON, MDSN or SDC will be responsible to carry out this task.</p> <p>F-226 continued next page ...</p>		

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F 226	Continued From page 40 for injury. LPN #7 stated in an interview conducted on 10/13/13, at 4:25 PM that she was aware residents were to be protected when an allegation of abuse was received, and that the alleged perpetrator was to be sent home immediately. However, LPN #7 confirmed the alleged perpetrator (CNA #12) was reassigned to another hallway to complete her shift after Resident #5 had voiced his/her complaint on 04/09/13. The LPN confirmed she notified the SSD of the allegation, but stated she did not reassign CNA #12 and could not recall who directed her to reassign the nurse aide to continue to provide direct care to residents in another area of the facility. Interview conducted with the SSD on 10/13/13, at 9:35 AM, revealed she immediately initiated an investigation into the allegation after LPN #7 notified her at home of the reported incident on 04/09/13. The SSD stated the alleged perpetrator (CNA #12) had been moved to another hall to work by the time she arrived at the facility on 04/09/13. The SSD stated the investigation consisted of statements from the alleged perpetrator (CNA #12) and Resident #5. The SSD stated she had been trained "over the years" by the different administrative staff on how to conduct investigations of alleged abuse. In addition, the SSD stated she had been trained to send the alleged perpetrator home when an allegation of abuse was reported and to report the allegations immediately to the state agencies. The SSD stated the decision to report or not report the allegation to the state agencies was made by the IDT after the investigation had been completed.	F 226	F-226 Continued... The Administrator will provide oversight daily, including weekends, by discussion and/or reviewing and initialing the audits after review to ensure residents were protected, reporting was timely and the investigations were thorough through interviews with staff and residents, physical head to toe assessments, record reviews. In addition, the Managing Partner will review twice weekly with the Administrator in an informal format to ensure that allegations are reported timely, residents are protected, receive appropriate assessments, perpetrators are suspended or terminated and a thorough investigations are being performed which includes through interviews with staff and residents, head to toe physical assessments and record reviews, any alleged abuse, neglect; misappropriation of funds identified will be investigated in a timely manner to ensure the resident's safety with an assessment for any physical or psychosocial issues. Immediate suspension of staff involved and timely notification of state agencies will be completed immediately, by SSD, DON, ADON, MDSN, SDC, Administrator, NS or UCN. F-226 continued next page...		

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F 226	Continued From page 41 Interview with the DON on 10/13/13, at 10:50 AM, revealed she was not aware of the allegation until the Grievance/Complaint Report was discussed in the IDT meeting on 04/10/13. The DON stated the alleged perpetrator (CNA #12) had been permitted to return to her regular assignment as scheduled and no further disciplinary action was taken. In addition, the DON stated the allegation had not been considered as abuse, had not been reported, and no disciplinary action taken with the alleged perpetrator (CNA #12). The DON stated she considered abuse to be anything done "maliciously" to a resident. The Administrator stated in interview conducted on 10/13/13, at 1:40 PM, the alleged perpetrator (CNA #12) should have been suspended immediately pending the outcome of the facility's investigation. However, according to the Administrator, the IDT discussed the investigation on 04/09/13, and decided abuse had not occurred and no further action was required. The Administrator stated he considered abuse to be anything that might "inhibit the health and welfare of the resident" and the facility had become "complacent" when evaluating allegations of abuse, neglect, exploitation, and misappropriation of resident property. 5. Review of Resident #6's medical record revealed physician's orders, dated 08/23/13, for facility staff to administer 0.5 milligram (mg) of Risperidone (antipsychotic) to the resident on a daily basis. Review of a Grievance/Complaint Report dated 08/30/13, revealed Resident #6's family reported on 08/30/13 facility staff had failed to administer	F 226	F-226 continued ... The DSS, DON, Administrator, ADON, MDSN or NS will conduct an abuse monitor, (See Exhibit # 7: Village of Lebanon, LLC Abuse Monitor), weekly x 4 weeks, then every month for three months, then quarterly thereafter and report to Quality Assurance Committee for guidance, direction and oversight. In Addition, The DSS, DON, ADON, MDSN or NS will complete an Allegations of abuse, neglect or misappropriations Quality Assurance Log to be reported on a daily basis to the IDT Committee (Morning Meeting) and will be reviewed daily by the Administrator or designee (SDN) and Director of Nursing or designee (ADON/MDSN) for Tracking and trending such as, discovery of any trends in the report, allegations occurring on the a certain shift, day, night, evening, whether or not a certain employee, event or situation had developed a pattern that would require additional investigation such as, interviews with staff and residents, head to toe physical assessments, record reviews. In Addition, The DSS, DON, ADON, MDSN or NS will complete an Allegations of abuse, neglect or misappropriations Quality Assurance Log to be reported on a daily basis to the IDT Committee (Morning Meeting) and will be reviewed daily by the Administrator or designee (SDN) and Director of Nursing or designee (ADON/MDSN) for Tracking and trending such as, discovery of any trends in the report, allegations occurring on the certain shift, F-226 Continued next page...		

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F 226	<p>Continued From page 42</p> <p>the Risperidone to Resident #6, as ordered by the physician, for the "past few days."</p> <p>Review of the facility's investigation revealed the facility verified Resident #6 received the correct medications, including Risperidone, on 08/29/13; however, the facility failed to verify if staff had administered the Risperidone to Resident #6 prior to 08/30/13.</p> <p>Interview conducted with the SSD on 10/12/13, at 6:15 PM, revealed the Grievance/Complaint Report was reviewed in the daily IDT meeting and she failed to reveal in the meeting the medication (Risperidone) had not been administered for several days prior to 08/30/13. The SSD stated the allegation was not reported to the state agencies or further investigation conducted after the IDT determined the medications had been given on 08/29/13.</p> <p>The DON stated in interview conducted on 10/13/13, at 10:40 AM, that she had not realized the allegation was that Resident #6 had not received the prescribed medications for more than one day (08/29/13). The DON stated, based on her findings, the allegation had not been considered as abuse/neglect and confirmed no further investigation had been conducted and the allegation had not been reported to the state agencies.</p> <p>6. Review of documentation revealed the Speech Therapist (ST) had discharged Resident B from Speech Therapy on 05/30/13. A review of the ST Discharge Summary Note for Resident B, dated 05/30/13, revealed the resident required close monitoring of meals and should receive bite-size food portions alternated with solids and liquids</p>	F 226	<p>F-226 continued...</p> <p>Day, night, evening, whether or not a certain employee, event or situation had developed a pattern that would require additional investigation. This log will be turned in monthly to the QA committee for review and oversight, (See Exhibit #6: Allegations of Abuse, Neglect, Misappropriations Quality Assurance Log) The Abuse reporting form was revised on October 14, 2013 by the IDT. (See Exhibit # 9: Abuse Reporting/Investigation Worksheet), which will have oversight by Assistant Administrator and/or Administrator on a daily basis with oversight by Medical Director through Monthly Quality Assurance. Quality Assurance/Risk Management Policy was updated October 13, 2013 to include specific oversight of Abuse, Neglect, Misappropriation oversight and input from Medical Director. (See Exhibit # 10: Quality Assurance Policy).</p>	11/01/2013	

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F 226	<p>Continued From page 43</p> <p>due to a diagnosis of Dysphagia. The ST further noted the resident required 1:1 assistance with meals to aid with oral clearance. Review of the October 2013 physician's orders for Resident B revealed the resident was to receive a regular puree diet with honey-thickened liquids.</p> <p>Review of the Grievance/Complaint Report dated 09/25/13, revealed a family member of another resident was in the facility's dining room during the evening meal on 09/24/13. The report revealed the family member reported he/she had observed Resident B choking while being assisted/fed by a nurse aide, while the nurse aide was looking at the television and was unconcerned when the resident began coughing/choking. The report further alleged the nurse aide was rude and wiped the resident's mouth "hard" and jerked the resident's bib off.</p> <p>Review of the facility's investigation revealed the facility obtained witness statements from the alleged perpetrator (CNA #8), another nurse aide, and the restorative nurse. However, there was no evidence the facility suspended/removed the alleged perpetrator during the investigation. In addition, there was no evidence the facility's investigation included a physical assessment of Resident B to ensure the resident was not harmed and no evidence the facility reported the allegation to the state agencies.</p> <p>Interview conducted with the SSD on 10/12/13, at 2:50 PM, revealed the SSD had received facility training on how to conduct investigations into alleged abuse "over the years." The SSD also stated she had been trained to send an alleged perpetrator home when an allegation of abuse was reported and to report the allegations</p>	F 226			

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F 226	<p>Continued From page 44</p> <p>immediately to the state agencies. The SSD stated the IDT made the decision to not report the allegation to the state agencies because it was determined the allegation did not meet the criteria for abuse.</p> <p>Interview conducted with the DON on 10/13/13, at 11:05 AM, revealed, in accordance with facility policy, an alleged perpetrator would be suspended or removed from direct care when an allegation of abuse was reported. The DON further stated the alleged perpetrator (CNA #8) in the allegation related to Resident B was not suspended or removed from direct care at the time the allegation was reported on 09/25/13 because she did not feel anything "inappropriate" had occurred. The DON stated although the IDT made the decision the allegation did not meet criteria for reporting to state agencies, she made the decision that no disciplinary action involving the alleged perpetrator was required.</p> <p>The Administrator stated in interview conducted on 10/13/13, at 1:40 PM, he thought the report had been discussed during the IDT meeting on 09/25/13. The Administrator stated he agreed with the decision made by the DON and the IDT not to remove the alleged perpetrator (CNA #8) from direct care and that the incident did not meet the criteria to report to the state agencies.</p> <p>7. A review of the Grievance/Complaint Reports dated 11/01/12, 11/05/12 (2 reports), and 11/20/12, revealed Residents D, E, #9, and #11 reported they were missing monies ranging from \$4.36 to \$30.00. Review of the facility's investigations revealed the facility reimbursed each resident's monies; however, there was no evidence the facility had reported these incidents</p>	F 226			

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F 226	<p>Continued From page 45</p> <p>to the state agencies; and no evidence the facility's investigation included resident interviews and interviews of staff caring for the residents at the time the money was reported missing.</p> <p>According to interview with the SSD, Administrator, and DON on 10/13/13, at 3:30 PM, the facility identified a trend of repetitive reports of missing monies that involved residents and employees in the facility. Interviews revealed the facility had suspected a nurse aide (CNA #11) was responsible. As a result, local police was contacted and money was "planted" on 11/27/12 to attempt to determine if CNA #11 was taking money from residents and/or staff. CNA #11 was terminated on 11/28/12 after it was determined he/she had taken the "planted" money. According to the Administrator, SSD, and DON, they determined the allegations of missing resident monies had been resolved after CNA #11 was terminated.</p> <p>However, continued review of the Grievance/Complaint Reports revealed four additional allegations of missing money were reported to the facility SSD from 01/02/13 to 08/30/13. Residents G and #9 reported missing money, and Resident F reported two instances when his/her money was missing. However, the facility failed to conduct resident and staff interviews related to the missing money and failed to report the allegations to the state agencies.</p> <p>Interview with the SSD, Administrator, and DON on 10/13/13, at 3:30 PM, revealed they determined none of the allegations related to misappropriation of resident personal property met the criteria for investigation and/or reporting.</p>	F 226			

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F 226	<p>Continued From page 46</p> <p>As a result, the facility failed to report the allegations of misappropriation to the state agencies.</p> <p>*An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy was received on 10/22/13, which alleged the Immediate Jeopardy was removed on 10/22/13.</p> <p>A review of the AOC revealed a complete anatomical assessment was conducted by the DON, Nursing Supervisor (NS), MDS Nurse, and Unit Coordinator (UC) for signs or symptoms of abuse for all in-house residents utilizing a newly implemented Abuse/Complaint Assessment Tool on 10/11/13. In addition, all alert and oriented residents as well as staff were interviewed by the DON, SSD, MDS Nurse, UC, Staff Development Coordinator (SDC), and Medical Records Director (MRD) to ensure no evidence of suspected abuse, neglect, exploitation, or misappropriation had not been reported. The AOC stated all past reports of abuse and grievances for the past year were reported to the state agencies and a "thorough investigation" was initiated into eight allegations related to abuse/neglect as well as protection of the resident during the investigation.</p> <p>The AOC revealed the facility's Abuse Policy was reviewed and updated in accordance with the State Operations Manual (F225 and F226) on 10/10/13. In-service training was initiated on 10/10/13 and completed on 10/12/13, for 100 percent of facility employees by the Staff Development Coordinator (SDC).</p> <p>The AOC further revealed the Administrative staff, including the Administrator, DON, and SSD, was counseled by the Corporate Officer and retrained</p>	F 226			

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F 226	<p>Continued From page 47 by the Staff Development Nurse on 10/10/13 on the Abuse policy.</p> <p>Further review of the AOC revealed the facility would ensure continued compliance through the completion of a daily Continuous Quality Improvement (CQI) form to be reviewed during the daily CQI meeting to ensure all concerns/grievances have been "thoroughly reviewed" and all issues have been addressed per policy with appropriate reporting to the state agencies. The CQI form will be reviewed daily by the Administrator and bi-weekly by the Managing Partner. In addition, the AOC noted an Abuse Log would be completed daily by the SSD, DON, ADON, MDS Nurse, or NS and reviewed daily by the Administrator, DON, or designee. The Administrator would provide daily oversight to ensure all allegations of abuse, neglect, misappropriation of property identified will be investigated in a timely manner, involved staff was immediately suspended, and state agencies were notified immediately. The AOC further indicated the Allegations of Abuse Log would be utilized to track/trend reported allegations and would be reviewed monthly with the QA Committee.</p> <p>**The surveyors validated the corrective action taken by the facility as follows:</p> <p>Review of the facility's documentation revealed a 100 percent audit had been conducted of all in-house residents on 10/11/13 by the DON to identify any potential signs or indicators of abuse, neglect, or misappropriation. A review of the daily census for 10/11/13, verified all residents had been assessed for abuse, neglect, and misappropriation. Review of the</p>	F 226			

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F 226	<p>Continued From page 48</p> <p>Abuse/Complaint question assessment tool and interviews conducted with residents and facility staff revealed no signs or symptoms of abuse were evident. A review of the facility's investigations revealed the facility had reopened the allegations identified in the AOC and had conducted an investigation which included suspension/termination of the alleged perpetrators and appropriate reporting of each allegation immediately to the state agencies. Interview conducted with the DON on 10/23/13 revealed the investigations had been reopened and witness interviews and other pertinent data had been used to determine if the allegation was substantiated or unsubstantiated. The DON also provided evidence that protection had been provided for the residents during the investigation and the allegations had been reported to the state agencies as indicated in the AOC.</p> <p>Review of the facility's Abuse policy revealed the policy had been revised to reflect interventions to be utilized to deal with reporting, protection, and investigation of all allegations of abuse. A review of the facility's in-service sign-in sheets, pre/post tests, and interviews with staff (RN #1, LPN #10, LPN #11, CNAs #13, #14, #15, and #16, Housekeeping Staff Members #1 and #2, and Dietary Staff Member #1) on 10/23/13, verified staff had been in-serviced on 10/10/13, 10/11/13, 10/12/13, 10/14/13, 10/15/13, 10/17/13, 10/19/13, and 10/21/13, as stated in the AOC. Staff further revealed they had been in-serviced on the revised/updated abuse policy to include timely reporting of any allegation of abuse/neglect by the use of a pre/post test. The revised abuse policy material included educating staff on how to identify, assess, complete "thorough investigations," and timely reporting.</p>	F 226			

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F 226	Continued From page 49 Review of the Performance Improvement Forms dated 10/10/13 verified counseling was provided for the Administrator, DON, and the SSD by the Corporate Officer. In addition, review of the in-service records dated 10/11/13 revealed retraining related to the Abuse policy was provided to the Administrator, DON, and the SSD on 10/11/13. Interviews conducted with the Administrator, DON, and the SSD on 10/23/13 confirmed counseling and reeducation had been provided as stated in the AOC. Interviews conducted with members of the IDT team (Administrator, SSD, DON, UC, Dietary Manager, Activities Director, SDC, and MDS Nurse) on 10/23/13, revealed the allegations of abuse, neglect, exploitation, and misappropriation were reviewed daily during the IDT meeting to ensure the allegations/concerns were appropriately reported, investigated, and resident protection provided. Review of the Abuse/Complaint question assessment tool and interviews conducted with Residents #3, I, J, K, L, and M on 10/23/13, verified staff had interviewed them daily from 10/11/13 to 10/18/13 to determine if any abuse had occurred. Further review of the abuse/complaint questionnaire revealed the Administrator, DON, and Managing Partner reviewed the information daily. Interview conducted with the Administrator on 10/23/13, at 5:45 PM, revealed he reviewed the Abuse Log daily and any identified discrepancies were corrected immediately to ensure all allegations of abuse, neglect, or misappropriation were investigated and reported, and protection for residents was provided appropriately. The	F 226			

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F 226	Continued From page 50 Administrator stated the Abuse log would be utilized as a tracking/trending tool to report any trends and problems to the QA Committee.	F 226			
F 253 SS=D	483.15(h)(2) HOUSEKEEPING & MAINTENANCE SERVICES The facility must provide housekeeping and maintenance services necessary to maintain a sanitary, orderly, and comfortable interior. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and a review of facility policies, it was determined the facility failed to provide maintenance and housekeeping services to maintain a sanitary, orderly, and comfortable interior. Observations during the environmental tour on 10/08/13, beginning at 11:15 AM, revealed the carpet on the Davis Hall had several stained areas, the armrests on a Geri-chair in room 138-2 were torn, and a floor mat in room 124-1 was torn. The findings include: Review of the facility's policy titled, "Accident/Hazard Risk Assessment," dated 10/01/12, revealed facility staff conducted "walk-throughs" of all departments and observed for, but not limited to, unstable/uneven floor surfaces, defective assistive devices/equipment, and spills on the floors. The policy revealed staff was to complete "work orders" that identified problems, the "work orders" were to be given to the Nursing Supervisors, and they were to give the "work order" to the Maintenance Director (MD) to process and repair.	F 253	F 253 1. A. Carpet was cordoned off until such time the carpet could be cleaned and sanitized. B. The resident was removed from the Geri-chair immediately. The Geri chair was taken out of service for repair and replaced with another chair. Floor mat inside room 124-1 was replaced with a non torn mat immediately. 2. A. An inspection of the carpeted area was performed by the administrator and Housekeeping Director. There were other areas found to have stains as well. It was determined to affect all resident in the unit that had carpeted floors. The areas were cleaned with buffer and disinfected with appropriate products. B. An inspection of all Geri chairs in the facility was performed by the Director of Maintenance to determine if repairs were needed. Residents that were found to be in chairs that needed repair were removed from them and placed in appropriate chairs while repairs were made. F-253 Continued next page...		

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F 253	<p>Continued From page 51</p> <p>Observation during the environmental tour on 10/08/13, beginning at 11:15 AM, revealed:</p> <ol style="list-style-type: none"> The carpet on the Davis Hall had several stained areas. A Geri-chair was observed in resident room 138-2 and the armrests on the chair were worn and torn. A floor mat in resident room 124-1 was torn and the inside padding protruded from the mat. <p>Interview with the Housekeeping Director on 10/10/13, at 3:37 PM, revealed she cleaned the carpet on Davis Hall three to four times weekly and used a "cleaning solution" on the buffer pad for stain removal. The Housekeeping Director stated that the facility had a professional company to come in every three to six months to clean the carpet; however, she could not remember when the professional company had last cleaned the carpet.</p> <p>An interview conducted with the Maintenance Director on 10/10/13, at 3:30 PM, revealed he and the Administrator made daily rounds throughout the facility to observe for anything/items in need of repair. He said facility staff that identified maintenance or housekeeping issues was required to fill out a work order and turn it in to the Nursing Supervisors; the Nursing Supervisors were to turn the work orders into the Maintenance Director, and he, or housekeeping staff, would perform the repairs and/or cleaning. The Maintenance Director said he was aware that the carpet "was an issue" but the Managing Partner had not approved to have the carpet</p>	F 253	<p>F-253 Continued ...</p> <p>C. A room to room inspection was performed by the Director of Housekeeping throughout the entire facility for other torn or worn mats, there were no other residents found to have been affected by the deficient practice.</p> <p>3. A review of the safety maintenance policy revealed that it was not all encompassing and Stains, Geri chairs as well as floor mats were added to the policy (See Exhibit #12, Safety Policy).</p> <p>4. An audit was developed by the IDT (See Exhibit # 13, Environmental Inspection Audit) to monitor for stains, worn equipment including Geri-chairs, and floor/fall mats. Beginning week of 10/14/2013 This audit will be performed by Director of Housekeeping 3x weekly times 3 weeks, then 2x/weekly times 2 weeks, or until 100% compliance is achieved, then monthly thereafter. Finding is to be report monthly to the Quality Assurance Committee for oversight and direction.</p>	11/14/13	

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F 253	Continued From page 52 replaced. Further review with the Maintenance Director revealed that he was aware of the Geri-chair in room 138-2 and the Administrator had ordered the material to repair the armrests. The Maintenance Director also stated he was not aware of the torn floor mat in room 124-1 and that he had not received a work order for the needed repairs. An interview with the Administrator on 10/10/13, at 3:40 PM, revealed that he made daily rounds with the Maintenance Director and also had other facility staff that may have "fresh eyes" to observe the facility for any problem areas. He said that a copy of every work order is brought to the Interdisciplinary Team (IDT) meeting for discussion of repair. According to the Administrator, the carpet was a concern and it was "on hold" due to the possibility of relocating to another facility. The Administrator stated that he had the material to repair the Geri-chair arms but had not gotten to it and was not aware of the floor mats in Room 124-1.	F 253			
F 282 SS=D	483.20(k)(3)(ii) SERVICES BY QUALIFIED PERSONS/PER CARE PLAN The services provided or arranged by the facility must be provided by qualified persons in accordance with each resident's written plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, and record review it was determined the facility failed to provide services in accordance with each resident's written plan of care for one of fifteen	F 282	F 282 1. A fall mat was immediately provided for resident #4 to match care plan for having a mat on both sides of the bed. She was assessed for any adverse affects to deficient practice and none were discovered. F-282 Continued next page...		

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F 282	<p>Continued From page 53</p> <p>sampled residents (Resident #4). The facility failed to provide fall mats for Resident #4 in accordance with the plan of care developed for this resident.</p> <p>The findings include:</p> <p>Review of the facility's policy titled "Interdisciplinary Care Plan," with a revision date of 10/01/12, revealed the care plan was used as a guide to provide nursing care to the resident. The care plan was based on clinical practice and was a guide for staff to insure the decline in a resident's status was avoidable if at all possible.</p> <p>Record review revealed Resident #4 was 96 years old and had diagnoses that included Senile Dementia, Alzheimer's Disease, and Abnormal Posture. According to the Comprehensive Assessment dated 09/15/13, the facility assessed Resident #4 to be at risk for falls. Review of care plans revealed facility staff identified Resident #4 to be at risk for falls or injuries and developed interventions that included the use of a low bed with fall mats on the floor on both sides of the bed.</p> <p>Observations conducted of Resident #4 on 10/08/13 at 3:00 PM, 4:30 PM, 5:35 PM, and 5:55 PM, and on 10/09/13 at 8:30 AM, 9:25 AM, 10:10 AM, and 11:30 AM, revealed the resident had only one fall mat on the floor located on the left side of the resident's bed.</p> <p>Interview conducted on 10/10/13 at 10:20 AM with Certified Nursing Assistant (CNA) #1 revealed she had been assigned to provide services to Resident #4 on 10/08/13. Further interview revealed the CNA was not aware</p>	F 282	<p>F-282 Continued...</p> <ol style="list-style-type: none"> 2. An audit of all care plans was performed by the DON, ADON and MDSN to determine if any other residents were at risk for due to the deficient practice. No other residents were found to be at risk due to the deficient practice. 3. The Interdisciplinary Care Plan Policy was updated on 10/14/2013 to include the use of the Kardex as a means of continuity of the care plan and <u>all</u> direct care staff were in-service by the Director of Nursing, ADON, MDS and Staff Development Nurse Coordinator as to the use of Kardex in following the Residents Plan of Care (See Exhibit #19, Physician Orders, Interdisciplinary Care Plan, Kardex In-service and sign in sheet) on 10/14/2013 through 10/22/2013. 4. An Interdisciplinary Care Plan Audit was developed (See Exhibit #20, Interdisciplinary Care Plan Audit) beginning week of 10/14/2013, the audit will be <p>F -282 Continued next page...</p>		

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 185267	(X2) MULTIPLE CONSTRUCTION A. BUILDING _____ B. WING _____	(X3) DATE SURVEY COMPLETED 10/23/2013
NAME OF PROVIDER OR SUPPLIER CEDARS OF LEBANON NURSING CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 337 SOUTH HARRISON STREET LEBANON, KY 40033	
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F 282	Continued From page 54 Resident #4 had been assessed to have a fall mat on each side of the bed. Interview with CNA #2 on 10/10/13 at 10:25 AM, revealed the CNA had been assigned to provide care for Resident #4 on 10/09/13. According to CNA #2, she was not aware two fall mats were to be used for Resident #4. An interview with the Unit Coordinator on 10/10/13 at 10:30 AM revealed the Unit Coordinator observed residents numerous times on a daily basis to ensure care needs were met. The Unit Coordinator stated she had had not observed that staff had failed to utilize a fall mat on each side of Resident #4's bed.	F 282	F -282 Continued... performed by the DON, ADON, MDSN or designee on 10% of the charts and residents weekly for 4 weeks, then monthly x 1 month then quarterly x 2 or until 100% compliance has been achieved, longer if 100% compliance not achieved and maintained. All findings will be reported to the Quality Assurance Committee for review and direction.	11/14/2013
F 309 SS=D	483.25 PROVIDE CARE/SERVICES FOR HIGHEST WELL BEING Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. This REQUIREMENT is not met as evidenced by: Based on observation, interview, record review, and facility policy review, it was determined the facility failed to ensure necessary care and services to attain the highest practical physical well-being were provided for one of fifteen sampled residents (Resident #8). Review of the medical record for Resident #8 revealed a	F 309	F 309 1. Resident #8, "Heel Float Boots" were immediately placed on resident #8. A complete assessment was performed on Resident #8 it was found that the resident did not suffer an ill effects from the deficient practice. 2. An audit of all physician orders was performed by the DON, ADON and MDSN to determine if any other residents were at risk for due to the deficient practice. No other residents were found to be at risk due to the deficient practice. F-309 Continued next page...	

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F 309	<p>Continued From page 55</p> <p>physician's order, dated 08/22/13, for the resident to have "Heel Float Boots" to both feet at all times for wound prevention. However, the facility failed to provide the services as ordered by the physician to Resident #8.</p> <p>The findings include:</p> <p>Review of the facility's policy titled, "Physician Delegation of Task," dated 10/01/12, revealed a care plan was to be developed according to the physician's orders, and attainable interventions would be put into place.</p> <p>Review of the medical record for Resident #8 revealed the facility admitted the resident on 02/17/11, with diagnoses that included Urinary Retention, Diabetes Mellitus, Osteoarthritis, and Depression. Review of the physician's orders for Resident #8 revealed an order, dated 08/22/13, for "Heel Float Boots to be worn on both feet at all times for wound prevention."</p> <p>Observations conducted on 10/08/13, at 3:03 PM, 3:57 PM, and 4:50 PM revealed Resident #8 was up in a Geri-chair in the hallway; at 6:06 PM, the resident was observed sitting in a Geri-chair in the dining room. Observations conducted on 10/09/13 at 8:47 AM, 9:28 AM, and 10:37 AM revealed Resident #8 sitting up in a Geri-chair in the hallway. Observations revealed Resident #8 did not have the heel float boots in place during the observations conducted on 10/08/13 and 10/09/13.</p> <p>An interview conducted with Certified Nurse Aide (CNA) #17 on 10/09/13, at 1:35 PM, revealed she provided care to Resident #8 during the 6:00 AM to 2:00 PM shift on 10/08/13 and 10/09/13. CNA</p>	F 309	<p>F-309 Continued...</p> <p>3. The Physician Delegation of Tasks Policy was reviewed by The Interdisciplinary Team consisting of a blend of Administrator, DON, ADON, MDS, SDC, SSD, UC, among others and found to be in compliance with CMS regulations Licensed staff were In serviced on Physicians orders and transcription to ensure a means of continuity of the care plan Care (See Exhibit #19, Physician Orders, Interdisciplinary Care Plan, Kardex In-service and sign in sheet) on 10/14/2013 through 10/22/2013.</p> <p>4. An audit was developed to monitor the following of Physician Orders. (See Exhibit #21, Physician Order Verification Audit). Beginning week of 10/14/2013 the audit will be performed by the DON, ADON, MDSN or designee on 10% of the charts and residents weekly for 4 weeks, then monthly x 1 month then quarterly x 2 quarters or until 100% compliance has been achieved, longer if 100% compliance not achieved. All findings will be reported to the Quality Assurance Committee for review and direction</p>	11/14/2013	

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F 309	Continued From page 56 #17 stated she was not aware that Resident #8 was to wear the heel float boots at all times. CNA #17 stated she thought Resident #8 was only to wear his/her heel float boots when he/she was in bed. An interview conducted with Registered Nurse (RN) #2 on 10/09/13, at 1:28 PM revealed Resident #8 was to wear the heel float boots while in bed according to Resident #8's Care Plan. An interview with the Unit Coordinator on 10/10/13 at 10:30 AM revealed the Unit Coordinators observed residents numerous times on a daily basis to ensure care needs were met; however, occasionally care needs of the residents were overlooked. An interview conducted with the Director of Nursing (DON) on 10/10/13, at 3:52 PM, revealed the facility reviewed medical records to ensure services were being provided as ordered by the physician; however, she had not identified that staff had not utilized the heel float boots for Resident #8 on a daily basis. The DON acknowledged the physician's order was for the heel float boots to be worn at all times by Resident #8. The DON said the order must have been transcribed inaccurately and the mistake had not been identified when the medical records were reviewed.	F 309			
F 363 SS=E	483.35(c) MENUS MEET RES NEEDS/PREP IN ADVANCE/FOLLOWED Menus must meet the nutritional needs of residents in accordance with the recommended dietary allowances of the Food and Nutrition	F 363	F 363 1. The residents were immediately provided condiments for their meal as was listed on the menu. 2. A survey of all residents' trays by the Director of Dietary Services during meal time revealed that all trays lacked the condiments that were listed on the menu. Condiments that were listed on menu were provided to each resident that was affected. F-363 Continued next page...		

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F 363	<p>Continued From page 57</p> <p>Board of the National Research Council, National Academy of Sciences; be prepared in advance; and be followed.</p> <p>This REQUIREMENT is not met as evidenced by: Based on observation, interview, and review of the facility's policy, it was determined the facility failed to follow the posted menu at the noon meal on 10/09/13. Cheeseburgers, "tater tots," and condiments (ketchup, mustard, and mayonnaise) were on the menu to be served to the facility's residents. However, observations of the meal service revealed the facility failed to ensure the condiments were placed on the residents' trays as specified on the posted menu.</p> <p>The findings include:</p> <p>Review of the Dining Services policy, dated 10/12/12, revealed menus were to be followed on a daily basis and any changes were to be posted on the menu substitution log.</p> <p>Review of the posted menu for the noon meal on 10/09/13, revealed the menu specified that condiments (ketchup, mustard, and mayonnaise) were to be served with the meal.</p> <p>Observations of the noon meal on 10/09/13, revealed residents were served cheeseburgers, tater tots, sandwich garnishes (tomato and onion), and cheesecake. Further observation revealed dietary staff had not placed any condiments (ketchup, mustard, or mayonnaise) on the residents' trays for the cheeseburgers and tater tots as specified on the posted menu. Observation in the dining room revealed</p>	F 363	<p>F-363 Continued...</p> <p>3. The dietary manager was re educated on the need to follow menus as they are published for the residents (See Exhibit #14, Counseling form), this was performed 10/13/2013. Staff was in serviced on the Dietary 7 day menu policy on 10/14/2013 by the dietary manager. (See Exhibit #15, 7 day Menu Policy and sign in sheet).</p> <p>4. An audit was developed to ensure the accuracy of the trays and that condiments were provided. (See Exhibit #16, Tray Accuracy Audit). Beginning week of 10/14/2013, the audit is to be performed by the Director of Dietary Services daily x 7 days then weekly x one month, then quarterly thereafter. The results of the audit will be reported to Quality Assurance Committee for oversight and direction.</p>	11/14/2013	

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F 363	Continued From page 58 condiments were placed on a cart in the dining room. Staff serving residents in the dining room gave residents condiments only when residents requested condiments. Interview with seven alert residents attending the group interview conducted on 10/09/13 at 10:45 AM, revealed condiments were not put on the residents' trays. The residents stated sandwiches/burgers were too dry without any condiments, and the French fries tasted better with ketchup. The residents stated the only time they received condiments such as ketchup, mustard, and mayonnaise was when they requested them.	F 363			
F 371 SS=D	The Dietary Manager (DM) acknowledged in interview conducted on 10/09/13 at 11:35 AM that kitchen staff had not placed condiments on the residents' meal trays, but condiments (ketchup, mustard, or mayonnaise) were on a cart available for residents who could request them. 483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by:	F 371	F 371 1. The resident #6 was immediately provided a fresh covered desert for their meal. 2. A survey of all residents' trays and observation by the Director of Dietary Services during meal time revealed that no other residents were affected by the deficient practice. All trays were delivered in accordance with state regulations. 3. The Director of Dietary Services was counseled and directed to in-service all dietary employees on proper (See Exhibit #14, Counseling form), the dietary sanitation policy was reviewed and updated on 10/14/2013. (See Exhibit #17, Dietary Sanitation Policy and sign in sheet). Staff was in serviced by the Dietary Director on 10/14/201, as to No food allowed to leave kitchen uncovered. F-371 Continued next page...		

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F 371	<p>Continued From page 59</p> <p>Based on observations, interview, and review of the facility's policy, it was determined the facility failed to ensure foods were served to residents under sanitary conditions for one of fifteen residents (Resident #6). Observations of the evening meal on 10/08/13, on the Raley Hall revealed staff served a meal tray with the dessert uncovered and exposed to the environment.</p> <p>The findings include:</p> <p>Review of the Dining Room-Meal Service policy, dated 03/11/13, revealed foods would be served to all residents under safe and sanitary conditions.</p> <p>Observations, conducted during the evening meal on 10/08/13, revealed a closed meal cart was delivered to the Raley Hall at 5:35 PM. Staff was observed to distribute the trays to residents in their rooms. At 5:40 PM, facility staff was observed to remove a meal tray from the food cart and carry the tray down the hallway through the resident smoke area, to the back table of the facility's dining room (approximately 90 feet away from the food cart); the resident's dessert on the meal tray was noted to be uncovered.</p> <p>Interview with Certified Nurse Aide (CNA) #3 on 10/08/13, at 5:50 PM, revealed she had been trained to ensure food items were covered when delivering trays to the residents. CNA #3 stated dietary staff was responsible to cover the foods on the residents' trays. CNA #3 also stated she recognized the dessert was uncovered, but she did not think about covering the dessert before carrying the tray down the hall and into the dining room area.</p>	F 371	<p>F-371 Continued...</p> <p>4. An audit of the dietary carts was developed to ensure that no food was being served uncovered. (See Exhibit #18, Dietary cart audit). Beginning week of 10/14/2013, this is to be performed at every meal x 7 days, then daily x 1 week, then weekly x 1 month until 100 % compliance is achieved and maintained. The dietary manager will then provide oversight on an as needed basis to ensure that deficient practice is not repeated.</p>	11/14/2013	

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F 371	Continued From page 60 Interview conducted with the Dietary Manager (DM) on 10/10/13, at 1:15 PM, revealed the dessert should have been covered when being carried down the hallway. In addition, the Dietary Manager stated the CNA should have obtained a covered dessert from the kitchen before serving the tray to Resident #6. Interview with the Director of Nurses (DON) on 10/10/13, at 2:40 PM, confirmed all food items should be covered during tray delivery and the CNA should have obtained another dessert from the kitchen before serving the tray to Resident #6. The DON stated nursing staff had been trained to push the food cart from door to door to deliver resident trays.	F 371			
F 490 SS=J	483.75 EFFECTIVE ADMINISTRATION/RESIDENT WELL-BEING A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident. This REQUIREMENT is not met as evidenced by: Based on observations, interview, record review, review of the facility's investigation, and a review of policy/procedures it was determined facility's Administration failed to ensure its resources, including policies related to abuse and neglect, were used effectively and efficiently to maintain the highest practicable physical, mental, and psychosocial well-being for five of fifteen sampled residents (Residents #1, #5, #6, #7, and #9) and one unsampled resident (Resident B).	F 490	F-490 1. The affected RSD cases were re opened. The residents were immediately protected, and investigations consisting of staff, family and resident interviews as well as head to toe assessments were performed There were no signs, symptoms or indications of abuse found. RSD #1 Allegation: Mental Abuse, Original Date: 6/6/2013, Re-opened date: 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: (RSD #1) had inappropriate comments written on brief; (employee) was suspended by DON. An investigation was completed by the use of interviews with staff working at the time of incident as well as residents residing on the same unit. A head to toe assessment was completed on this resident by the DON, F-F490 Continued next page...		

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F 490	<p>Continued From page 61</p> <p>Review of the facility's 185 Grievance/Complaint Reports since the last standard survey conducted on 09/11/12, revealed 8 of these reports were allegations of abuse/neglect and 8 were allegations of misappropriation. However, the facility Administration failed to ensure these allegations were reported to the State agencies as required and failed to ensure the facility's investigations included witness interviews, record reviews and an assessment of the alleged victims (residents).</p> <p>Interview with the Administrator revealed the Grievance/Complaint Reports were reviewed during the daily Interdisciplinary Team (IDT) meetings regarding the alleged incidents of abuse and the appropriate decisions had been made regarding resident protection, reporting, and investigation for the reported allegations of abuse. According to the Administrator, allegations of abuse were not reported to the state officials unless the facility determined the allegation had occurred.</p> <p>The failure of the facility to ensure the facility was administered in a manner that enabled its resources to be used effectively and efficiently to attain or maintain the highest practicable physical wellbeing placed residents at risk. In addition, the facility's failure to immediately report all allegations of abuse, neglect, exploitation, and misappropriation of resident property, failure to protect residents during the course of an investigation of abuse, and failure to investigate an allegation of abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy with Substandard Quality of Care was determined</p>	F 490	<p>F-490 Continued...</p> <p>There were no bruising, skin tears or other evidence of injury found. Conclusion: It was found through interviews with staff, the message written on the brief was not intended for the resident. It was intended for another employee in a playful manner that would be checking the residents brief on next round. Unsubstantiated and re-educated (was placed on Follow-up Nursing/Facility Staff Performance Program, in which an a staff member is given specific goals related identified issues or potential issues to be reached and maintained throughout the program and is monitored daily while at work by Direct Nursing Staff and Supervisors and meets weekly with DON or ADON for one month for any reoccurrences of complaints or infractions and quality of care being rendered) (See Exhibit #11, Follow-up Nursing/Facility Staff Performance Program Policy and Form). RSD #5 Allegation: Physical Abuse, Original Date: 4/9/2013, Re-opened date: 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: RSD #5 states that (SRNA) pushed her, RSD protected, an investigation was conducted by use of interview with SRNA and (Resident #5) as well as interviews with other staff and residents on the same unit. A head to toe assessment was performed on RSD #5 that revealed no signs or symptoms of abuse were present, including but not limited to bruising, or skin tears. Conclusion: Resident is care planned for non compliance of care; this includes the use of Medical Bi PAP Machine. A determination was made that SRNA (employee) F-490 Continued next page...</p>		

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F 490	<p>Continued From page 62</p> <p>to exist on 09/25/13 at 42 CFR 483.13 Resident Behavior and Facility Practices. The facility was notified of the Immediate Jeopardy on 10/11/13. (Refer to F225 and F226.)</p> <p>An acceptable Allegation of Compliance (AOC) was received on 10/22/13, which alleged removal of Immediate Jeopardy on 10/22/13. The State Survey Agency determined the Immediate Jeopardy was removed on 10/22/13, which lowered the scope and severity to "D" while the facility monitors the effectiveness of systemic changes and quality assurances activities.</p> <p>The findings include:</p> <p>Review of the facility's Abuse policy, revised 01/23/13, revealed the facility had developed policies in an effort to prevent abuse and to ensure allegations of abuse would be investigated, residents protected from further potential abuse during the investigation, and the allegation would be reported to the state agencies. Further review of the facility's policy revealed the Administrator, Social Services Director, and Director of Nursing would be informed immediately of all allegations of abuse, neglect, exploitation, and misappropriation of resident personal property.</p> <p>1. Review of a Grievance/Complaint Report revealed Resident #7 reported to Licensed Practical Nurse (LPN) #2 on 09/25/13, that a night shift Certified Nurse Aide (CNA) was very rough when she provided care for the resident on 09/24/13 and had "jerked" the resident's arm and leg. The report revealed the facility had conducted an interview with Resident #7 and the resident reported the CNA was a "red-headed girl,</p>	F 490	<p>F-490 Continued...</p> <p>Assisted RSD #5 down in the wheelchair to keep her from falling. The resident was exhibiting signs of extreme confusion and lethargy potentially secondary to refusal to wear a Bi Pap Machine, causing resident #5 confusion, sleepiness, and to be slow moving. SRNA stated that she felt RSD #5 was going to fall over her bedside table so she (SRNA) sat her in the wheelchair to keep her from falling. SRNA is no longer employed with the facility. This was on going and completed on October 17, 2013. Appropriate state agencies were immediately notified.</p> <p>RSD #6 Allegation: Neglect, Original Date: 8/29/2013, Re-opened date: 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: Resident family stated RSD #6 did not receive his 1400 dose of Risperadol. An immediate head to toe assessment was completed; a thorough investigation was performed by interviewing all the nurses that had provided care to this resident and dispensed medications from the residents cart, a complete count of the Risperadol was performed. The count of the drug was correct, the MAR revealed that the Risperadol was given and signed out on the MAR. An interview with the RN revealed that the medication was given per physician orders. The resident had not had an increase in behaviors or agitation.</p> <p>F-490 Continued next page...</p>		

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F 490	<p>Continued From page 63</p> <p>who wore her hair on top of her head." Resident #7 reported the CNA stated, "I'm in a hurry and have other people to do and have to get out of here," and began "jerking" on him/her while she removed the resident's gown. Resident #7 stated the CNA hurt his/her arm and that he/she asked the CNA not to "be so rough and hateful," and began to cry. Documentation in the report revealed the facility identified the "red-headed girl" as CNA #4.</p> <p>Interview with the facility's Social Services Director (SSD) on 10/12/13, at 4:10 PM, revealed after the DON was notified the DON informed her that she would look at the statement from CNA #4 and determine later what action to take. The SSD stated she felt like the resident's report was an allegation of abuse and "I felt I should have called it in but I don't have the authority. It has always been the Administrator's final decision to call it in."</p> <p>Interview with the Administrator on 10/12/13, at 2:40 PM, revealed the incident dated 09/25/13, related to Resident #7 was reviewed in the Interdisciplinary Team (IDT) meeting and the team had viewed the report as a complaint and not an allegation of abuse. The facility Interdisciplinary Team (IDT) consisted of the following staff: Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Nurse, Social Services Director, Minimum Data Set Nurse, Director of Finance, Medical Records Director, Managing Partner, Director of Dietary, Housekeeping Director, Director of Maintenance, Unit Coordinator Nurse, Nurse Supervisor, and Restorative Program Nurse. The Administrator said that no injury occurred to Resident #7 and therefore he did not feel Resident #7, or other</p>	F 490	<p>F- 490 Continued...</p> <p>RSD #7</p> <p>Allegation: Physical Abuse Original Date: 9/25/2013, Re-opened date: 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: RSD #7 alleged that an aide was rough with care, In an interview with the roommate and resident it was alleged that CNA #4 instructed them (Residents) not to ring the call light as well. (This complaint was re-opened October 21, 2013. An investigation was completed with interviews of residents and staff) the CNA #4 (employee) was suspended by DON an investigation was completed, as well as, a physical assessment of resident was performed by DON and no injuries were noted such as bruising, skin tears, abrasions etc. Conclusion: Statements were taken from other residents and employees. Interviews of other residents revealed, that no other residents voiced complaints related to the roughness in care provided by CNA #4. The complaint from Resident #7 was investigated thoroughly, (through interviews with staff working the same shift including nurses and SRNA's, and other residents on the same unit) reported in a timely manner additional questioning of resident #7 she states that CNA #4 was only rough with her that one time stating that she was in a hurry to put my night gown on, rsd #7 states that employee has never been rough with her before and has not been rough since then. Rsd #7 states that she really likes the CNA #4 and does not mind that she takes care of her.</p> <p>F-490 Continued on next page...</p>		

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F 490	<p>Continued From page 64</p> <p>residents in the facility, needed to be protected. The Administrator also stated the IDT had decided not to report the incident to the state agencies.</p> <p>2. In addition, seven additional reports of alleged abuse, neglect, and exploitation were identified and revealed Resident #7 reported a night shift aide was "mean" to him/her on 09/11/13; Resident #9 reported staff refused to toilet him/her timely and reported he/she was "squeezed" when being transferred by facility staff; staff reported inappropriate markings were discovered on Resident #1's brief; Resident #5 alleged staff "pushed" him/her in the back; staff failed to administer medication as reported for Resident #6; and staff failed to provide appropriate care during mealtime involving Resident B. In addition, eight allegations of residents' missing monies were reported to the facility. However, the facility failed to report the allegations to the state agencies, failed to protect residents during an investigation, and failed to ensure the allegations were investigated by ensuring witnesses were interviewed, victims were assessed as indicated, and record reviews were conducted as indicated.</p> <p>The Administrator acknowledged in interview conducted on 10/13/13, at 1:40 PM that he was aware of each of the 16 allegations. The Administrator stated he felt like the Abuse policy had been followed and believed the IDT had been working at the facility for a long time and believed they were trained and were "doing their jobs." However, the Administrator stated staff had evidently "become complacent" regarding the established policies/procedures related to abuse.</p>	F 490	<p>F-490 Continued...</p> <p>Additional questioning took place with the roommate; she states that CNA #4 pulled rsd #7's crippled leg and that rsd #7 told her about it, roommate states that SRNA immediately apologized stating that she did not mean to pull her leg. Roommate states that SRNA has never been rough with her and she has never seen her be rough with any other resident, and that she likes SRNA. SRNA instructed those (Residents) not to ring the call light as well. (This complaint was re-opened October 21, 2013. A thorough investigation was completed with interviews of residents and staff). Upon further investigation with (Resident #7) it was determined that (Employee) stated "Do not put the call light on". RSD #7 also stated that she was unsure as to why (Employee) made that statement. Upon interviewing roommate she stated that (Employee) stated "Don't put your call light on" roommate stated that CNA #4 stated this as she was leaving the room both residents is unsure as to why the statement was made by (Employee). Staff that worked with CNA #4 was interviewed to determine if they knew that CNA #4 would tell residents not to put on the call light. Staff statements reflect that they had never witnessed CNA #4 speaking in that manner to any resident or asking them not to put on their call lights. Interviews with other residents revealed that they had never been told to not put on their call lights by CNA #4.</p> <p>F-490 Continued next page...</p>		

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F 490	<p>Continued From page 65</p> <p>*An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy was received on 10/22/13, which alleged the Immediate Jeopardy was removed on 10/22/13.</p> <p>A review of the AOC revealed a complete anatomical assessment was conducted by the DON, Nursing Supervisor (NS), MDS Nurse, and Unit Coordinator (UC) for signs or symptoms of abuse for all in-house residents utilizing a newly implemented Abuse/Complaint Assessment Tool on 10/11/13. In addition, all alert and oriented residents as well as staff were interviewed by the DON, SSD, MDS Nurse, UC, Staff Development Coordinator (SDC), and Medical Records Director (MRD) to ensure no evidence of suspected abuse, neglect, exploitation, or misappropriation had not been reported. The AOC stated all past reports of abuse and grievances for the past year were reported to the state agencies and a thorough investigation was initiated into eight allegations related to abuse/neglect as well as protection of the resident during the investigation.</p> <p>The AOC revealed the facility's Abuse Policy was reviewed and updated in accordance with the State Operations Manual (F225 and F226) on 10/10/13. In-service training was initiated on 10/10/13 and completed on 10/12/13, for 100 percent of facility employees by the Staff Development Coordinator (SDC).</p> <p>The AOC further revealed the Administrative staff, including the Administrator, DON, and SSD, was counseled by the Corporate Officer and retrained by the Staff Development Nurse on 10/10/13 on the Abuse policy.</p> <p>Further review of the AOC revealed the facility</p>	F 490	<p>F-490 Continued...</p> <p>It was determined that CNA #4 had established a pattern of complaints and review of past counseling's related to not following care plans, such as resident to be transferred by two person assist with the use of Hoyer lift, it was determined that the potential for abuse and neglect was present if she remained in the facility. A proactive approach was taken in this allegation to terminate the employee preventing any potential abuse, neglect, exploitation or misappropriation from this individual in the future, (Substantiated, Employee Terminated 10/21/2013).</p> <p>RSD #9 Allegation: Neglect, Original Date: 6/13/2013, Re-opened date: 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: (RSD #9) states that (employee) refused to take her to the bathroom, employee was suspended and a thorough investigation was completed. Conclusion: Additional investigation revealed that (Employee) did not refuse to take to the toilet as evident by interviews with staff members that were present at the time and residents roommate and residents that lived on the same unit as RSD #9.</p> <p>RSD #9: Allegation: Physical Abuse, Original Date: 06/05/2013, Re-opened date: 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: (RSD #9) states that a big girl squeezed her.</p> <p>F-490 Continued next page...</p>		

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F 490	<p>Continued From page 66</p> <p>would ensure continued compliance through the completion of a daily Continuous Quality Improvement (CQI) form to be reviewed during the daily CQI meeting to ensure all concerns/grievances have been thoroughly reviewed and all issues have been addressed per policy with appropriate reporting to the state agencies. The CQI form will be reviewed daily by the Administrator and bi-weekly by the Managing Partner. In addition, the AOC noted an Abuse Log would be completed daily by the SSD, DON, ADON, MDS Nurse, or NS and reviewed daily by the Administrator, DON, or designee. The Administrator would provide daily oversight to ensure all allegations of abuse, neglect, misappropriation of property identified will be investigated in a timely manner, involved staff was immediately suspended, and state agencies were notified immediately. The AOC further indicated the Allegations of Abuse Log would be utilized to track/trend reported allegations and would be reviewed monthly with the QA Committee.</p> <p>**The surveyors validated the corrective action taken by the facility as follows:</p> <p>Review of the facility's documentation revealed a 100 percent audit had been conducted of all in-house residents on 10/11/13 by the DON to identify any potential signs or indicators of abuse, neglect, or misappropriation. A review of the daily census for 10/11/13, verified all residents had been assessed for abuse, neglect, and misappropriation. Review of the Abuse/Complaint question assessment tool and interviews conducted with residents and facility staff revealed no signs or symptoms of abuse were evident. A review of the facility's</p>	F 490	<p>F-490 Continued...</p> <p>SRNA was suspended by DON and an investigation was conducted which included interviews with Staff that were present and residents on the same unit. A physical assessment was conducted, that revealed no bruising, skin tears or any other signs of abuse. Conclusion: Determination made that accused SRNA did not squeeze (Resident) after interview with SRNA and (Resident). (Resident) stated that she simply did not like the way she was transferred that time. Noted, (Resident) has diagnosis of severe rheumatoid arthritis and continuous generalized pain of entire body. In addition to: Obsessive Compulsive Disorder, Depression and Anxiety requiring mild and soft transfers. Allegation was unsubstantiated; SRNA was re-educated on proper transferring techniques with this resident). SRNA was able to demonstrate how transfer took place with RSD #9 and was directed on how to better transfer with this resident by the DON. Has diagnosis of severe rheumatoid arthritis and continuous generalized pain of entire body. In addition to: Obsessive Compulsive Disorder, Depression and Anxiety RSD #9, as related to her diagnosis of Obsessive Compulsive Disorder.</p> <p>F-490 Continued next page...</p>		

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F 490	<p>Continued From page 67</p> <p>investigations revealed the facility had reopened the allegations identified in the AOC and had conducted a more thorough investigation which included suspension/termination of the alleged perpetrators and appropriate reporting of each allegation immediately to the state agencies. Interview conducted with the DON on 10/23/13 revealed the investigations had been reopened and witness interviews and other pertinent data had been used to determine if the allegation was substantiated or unsubstantiated. The DON also provided evidence that protection had been provided for the residents during the investigation and the allegations had been reported to the state agencies as indicated in the AOC.</p> <p>Review of the facility's Abuse policy revealed the policy had been revised to reflect interventions to be utilized to deal with reporting, protection, and investigation of all allegations of abuse. A review of the facility's in-service sign-in sheets, pre/post tests, and interviews with staff (RN #1, LPN #10, LPN #11, CNAs #13, #14, #15, and #16, Housekeeping Staff Members #1 and #2, and Dietary Staff Member #1) on 10/23/13, verified staff had been in-serviced on 10/10/13, 10/11/13, 10/12/13, 10/14/13, 10/15/13, 10/17/13, 10/19/13, and 10/21/13, as stated in the AOC. Staff further revealed they had been in-serviced on the revised/updated abuse policy to include timely reporting of any allegation of abuse/neglect by the use of a pre/post test. The revised abuse policy material included educating staff on how to identify, assess, complete thorough investigations, and timely reporting.</p> <p>Review of the Performance Improvement Forms dated 10/10/13 verified counseling was provided for the Administrator, DON, and the SSD by the</p>	F 490	<p>F-490 Continued...</p> <p>She was placed on a Bowel and Bladder Plan by her Physician with interventions including; toilet every 2 hours at specific times. (Employee) was following the plan of care set forth by the Physician, and encouraging RSD #9 to wait until the set time to go. The bowel and bladder plan has been care planned and discussed many times with RSD #9. She is in agreement with the plan. She still continues to ask to go the toilet every 15-30 minutes. Staff continues to re-educate her on a daily basis as to her planned program set forth by her physician. Note: (Resident) has been on the scheduled Bowel and Bladder Program since 1/18/2013. The Allegation was Unsubstantiated, (Employee) was re-educated as to (Resident) specific Bowel and Bladder Program and proper toileting techniques.</p> <p>RSD "B"</p> <p>Allegations: Neglect, Original Date:9/25/2013, Re-opened date: 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: A visitor alleges that (RSD "B") was choking and coughing in the dining room, they state the aide did nothing for him and wiped his mouth "hard" (employee) was suspended and a thorough investigation was completed by interviewing staff that were present</p> <p>F-490 Continued next page...</p>	

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F 490	<p>Continued From page 68</p> <p>Corporate Officer. In addition, review of the in-service records dated 10/11/13 revealed retraining related to the Abuse policy was provided to the Administrator, DON, and the SSD on 10/11/3. Interviews conducted with the Administrator, DON, and the SSD on 10/23/13 confirmed counseling and reeducation had been provided as stated in the AOC.</p> <p>Interviews conducted with members of the IDT team (Administrator, SSD, DON, UC, Dietary Manager, Activities Director, SDC, and MDS Nurse) on 10/23/13, revealed the allegations of abuse, neglect, exploitation, and misappropriation were reviewed daily during the IDT meeting to ensure the allegations/concerns were appropriately reported, investigated, and resident protection provided.</p> <p>Review of the Abuse/Complaint question assessment tool and interviews conducted with Residents #3, I, J, K, L, and M on 10/23/13, verified staff had interviewed them daily from 10/11/13 to 10/18/13 to determine if any abuse had occurred. Further review of the abuse/complaint questionnaire revealed the Administrator, DON, and Managing Partner reviewed the information daily. Interview conducted with the Administrator on 10/23/13, at 5:45 PM, revealed he reviewed the Abuse Log daily and any identified discrepancies were corrected immediately to ensure all allegations of abuse, neglect, or misappropriation were investigated and reported, and protection for residents was provided appropriately. The Administrator stated the Abuse log would be utilized as a tracking/trending tool to report any trends and problems to the QA Committee.</p>	F 490	<p>F-490 Continued...</p> <p>During meal time as well as other residents that were present. A physical assessment was completed and no adverse affects were noted, lungs were clear, afebrile, vital signs were normal and resident was in no distress. Conclusion: RSD has worked with Speech Therapy and has had a five (5) modified Barium Swallow studies from 6/2012 to 5/2013. The physician is aware and has declined the use of a feeding tube. The RSD is care planned for choking and coughing episodes during meals. Staff is educated to stop feeding and allow him to "Cough and Clear" while being monitored by the feeding staff during these episodes. Unsubstantiated and re-educated as to proper feeding techniques and the potential for this resident to aspirate during feeding and when to alert nursing staff to potential aspiration.</p> <p>The facility replaced Residents Monies missing for the following residents #9, #11, D, E, F, and G when incident occurred. Employees were interviewed by the Director of Social Services, to determine events surrounding the missing monies. Residents that live on the same units aside from the RSDs listed above were interviewed. Residents were also interviewed at the time the monies went missing and there was no evidence found to imply that impropriety had occurred other than the disappearance of monies without reason or</p> <p>F-490 Continued Appendix "A"...</p>		

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F 520 F 520 SS=J	Continued From page 69 483.75(o)(1) QAA COMMITTEE-MEMBERS/MEET QUARTERLY/PLANS A facility must maintain a quality assessment and assurance committee consisting of the director of nursing services; a physician designated by the facility; and at least 3 other members of the facility's staff. The quality assessment and assurance committee meets at least quarterly to identify issues with respect to which quality assessment and assurance activities are necessary; and develops and implements appropriate plans of action to correct identified quality deficiencies. A State or the Secretary may not require disclosure of the records of such committee except insofar as such disclosure is related to the compliance of such committee with the requirements of this section. Good faith attempts by the committee to identify and correct quality deficiencies will not be used as a basis for sanctions. This REQUIREMENT is not met as evidenced by: Based on interview, record review, and review of the facility's policies and investigations, it was determined the facility failed to maintain a quality assessment and assurance committee that identified quality deficiencies and failed to develop and implement appropriate plans of action to correct identified deficiencies. A review of facility investigations conducted since the last	F 520 F 520	F-520 I. RSD #1 Allegation: Mental Abuse, Re-opened date: 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: (RSD #1) had inappropriate comments written on brief; (employee) was suspended by DON. An investigation was completed by the use of interviews with staff working at the time of incident as well as residents residing on the same unit. A head to toe assessment was completed on this resident by the DON, there were no bruising, skin tears or other evidence of injury found. Conclusion: It was found through interviews with staff, revealed the message written on the brief was not intended for the resident. It was intended for another employee in a playful manner that would be checking the residents brief on next round. Unsubstantiated and re-educated (was placed on Follow-up Nursing/Facility Staff Performance Program, in which an a staff member is given specific goals related identified issues or potential issues to be reached and maintained throughout the program and is monitored daily while at work by Direct Nursing Staff and Supervisors and meets weekly with DON or ADON for one month for any reoccurrences of complaints or infractions and quality of care being rendered) (See Exhibit #11, Follow-up Nursing/Facility Staff Performance Program Policy and Form) F-520 Continued next page...		

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F 520	<p>Continued From page 70</p> <p>standard survey on 09/11/12, revealed eight of these reports were allegations of abuse/neglect (involving Residents #7, #9, #1, #5, #6, and B) and eight were allegations of misappropriation (involving Residents #9, #11, D, E, F, and G). Interview and record review revealed administrative staff failed to ensure investigation of these allegations included witness and potential witness interviews, record review when indicated, and resident assessments when indicated. Administrative staff failed to protect residents and failed to report all allegations of abuse to the state agencies. The facility failed to recognize that their established abuse policy for reporting abuse was not effective, and therefore failed to implement any corrective actions to correct these problems. (Refer to F225, F226, and F490.)</p> <p>The facility's failure to identify quality deficiencies and failure to develop and implement appropriate plans of action to correct identified deficiencies regarding protecting residents from abuse and reporting/investigating allegations of abuse caused, or was likely to cause, serious injury, harm, impairment, or death to residents in the facility. Immediate Jeopardy was identified on 10/11/13 related to abuse. Immediate Jeopardy with Substandard Quality of Care was determined to exist on 09/25/13 at 42 CFR 483.13 Resident Behavior and Facility Practices (F225 and F226) and 42 CFR 483.75 Administration (F490 and F520). The facility was notified of the Immediate Jeopardy on 10/11/13.</p> <p>An acceptable Allegation of Compliance (AOC) was received on 10/22/13, which alleged removal of Immediate Jeopardy on 10/22/13. The State Survey Agency determined the Immediate</p>	F 520	<p>F-520 Continued...</p> <p>RSD #5 Allegation: Physical Abuse, Re-opened date: 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: RSD #5 states that (SRNA) pushed her, RSD protected, an investigation was conducted by use of interviews with SRNA and (Resident #5) as well as interviews with other staff and residents on the same unit. A head to toe assessment was performed on RSD #5 that revealed no signs or symptoms of abuse were present, including but not limited to bruising, or skin tears. Conclusion: Resident is care planned for non compliance of care; this includes the use of Medical Bi PAP Machine. A determination was made that SRNA (employee) assisted RSD #5 down in the wheelchair to keep her from falling. The resident was exhibiting signs of extreme confusion and lethargy secondary to refusal to wear a Bi Pap Machine, potentially causing her carbon dioxide levels to be increased, causing RSD #5 to exhibit signs of confusion, sleepiness, and to be slow moving. SRNA stated that she felt RSD #5 was going to fall over her bedside table so she (SRNA) sat her in the wheelchair to keep her from falling. SRNA is no longer employed with the facility. This was on going and completed on October 17, 2013. OIG, APS were notified.</p> <p>F-520 Continued next page...</p>		

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F 520	<p>Continued From page 71</p> <p>Jeopardy was removed on 10/22/13, which lowered the scope and severity to "D" while the facility monitors the effectiveness of systemic changes and quality assurances activities.</p> <p>The findings include:</p> <p>Review of the facility's policy and procedure entitled Quality Assurance/Risk Management Plan, (revised on 09/30/08) revealed the facility would establish and maintain a Quality Assurance/Risk Management Committee. The policy identified the Quality Assurance (QA) Committee would be responsible to assure the facility maintained compliance with all state and federal laws. The policy noted the Administrator was the QA chairperson and would also serve as the Risk Manager of the facility. In addition, the policy noted the QA Committee would supervise, make recommendations, and take corrective actions on all problems identified and the Administrator or designee had final responsibility for the implementation of plans of corrections for identified concerns.</p> <p>Interview with the Administrator on 10/13/13, at 1:40 PM, revealed the Grievance/Complaint Reports were placed on an Abuse Log each month by the SSD and the log was reviewed monthly by the QA Committee. The Administrator stated any unresolved issues noted on the Grievance Log would be discussed and an action plan would be implemented. The Administrator stated no unresolved concerns were identified on the Grievance Logs. The Administrator further stated the Grievance Log contained all grievances but no abuse/neglect concerns were listed on the Grievance Log since the IDT had reviewed these concerns during the daily</p>	F 520	<p>F-520 Continued...</p> <p>RSD #6 Re-opened date: 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: Resident family stated RSD #6 did not receive his 1400 dose of Risperadol. An immediate head to toe assessment was completed; a thorough investigation was performed by interviewing all the nurses that had provided care to this resident and dispensed medications from the residents cart, a complete count of the Risperadol was performed. The count of the drug was correct, the MAR revealed that the Risperadol was given and signed out on the MAR. An interview with the RN revealed that the medication was given per physician orders. The resident had not had an increase in behaviors or agitation.</p> <p>RSD #7 The complaint was re-opened on: 10/13/13, Date reported to OIG and APS was 10/13/13, completed Date: 10/17/13: RSD #7 alleged that an aide was rough with care, In an interview with the roommate and resident it was discovered that CNA #4 instructed them (Residents) not to ring the call light as well. (This complaint was re-opened October 21, 2013. An investigation was completed with interviews of residents and staff) the CNA #4 (employee) was suspended by DON an investigation was completed, as well as, a physical assessment of resident was performed by DON and no injuries were noted such as bruising, skin tears, abrasions etc. Conclusion: Statements were taken from other residents and employees.</p> <p>F-520 Continued...next page</p>		

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F 520	<p>Continued From page 72</p> <p>meetings and determined abuse/neglect had not occurred. The facility's Interdisciplinary Team (IDT) consisted of the following staff who attended the QA meetings: Administrator, Director of Nursing, Assistant Director of Nursing, Staff Development Nurse, Social Services Director, Minimum Data Set Nurse, Director of Finance, Medical Records Director, Managing Partner, Medical Director, Director of Dietary, Housekeeping Director, Director of Maintenance, Unit Coordinator Nurse, Nurse Supervisor, and Restorative Program Nurse. The Administrator also stated the breakdown in the system's failure to ensure all allegations of abuse, neglect, exploitation, and missing resident property were thoroughly investigated, resident protection, and reporting had not been identified through the QA program.</p> <p>*An acceptable Allegation of Compliance (AOC) related to the Immediate Jeopardy was received on 10/22/13, which alleged the Immediate Jeopardy was removed on 10/22/13.</p> <p>A review of the AOC revealed a complete anatomical assessment was conducted by the DON, Nursing Supervisor (NS), MDS Nurse, and Unit Coordinator (UC) for signs or symptoms of abuse for all in-house residents utilizing a newly implemented Abuse/Complaint Assessment Tool on 10/11/13. In addition, all alert and oriented residents as well as staff were interviewed by the DON, SSD, MDS Nurse, UC, Staff Development Coordinator (SDC), and Medical Records Director (MRD) to ensure no evidence of suspected abuse, neglect, exploitation, or misappropriation had not been reported. The AOC stated all past reports of abuse and grievances for the past year were reported to the state agencies and a</p>	F 520	<p>F-520 Continued...</p> <p>Upon further questioning of other residents, one other resident voiced complaint related to the roughness in care provided by CNA #4 and Resident #7. The complaint from Resident #7 was investigated thoroughly, reported in a timely manner additional questioning of resident #7 she states that CNA #4 was only rough with her that one time stating that she was in a hurry to put my night gown on, rsd #7 states that employee has never been rough with her before and has not been rough since then. Rsd #7 states that she really likes the CNA #4 and does not mind that she takes care of her. Additional questioning took place with the roommate; she states that CNA #4 pulled rsd #7's crippled leg and that rsd #7 told her about it, roommate states that SRNA immediately apologized stating that she did not mean to pull her leg. Roommate states that SRNA has never been rough with her and she has never seen her be rough with any other resident, and that she likes SRNA. SRNA instructed those (Residents) not to ring the call light as well. (This complaint was re-opened October 21, 2013. A thorough investigation was completed with interviews of residents and staff). Upon further investigation with (Resident #7) it was determined that (Employee) stated "Do not put the call light on". RSD #7 also stated that she was unsure as to why (Employee) made that statement. Upon interviewing roommate she stated that (Employee) stated "Don't put your call light on" roommate stated that CNA #4 stated this as she was leaving the room both residents is unsure as to why the statement was made by (Employee).</p> <p>F-520 Continued next page...</p>		

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F 520	<p>Continued From page 73</p> <p>thorough investigation was initiated into eight allegations related to abuse/neglect as well as protection of the resident during the investigation.</p> <p>The AOC revealed the facility's Abuse Policy was reviewed and updated in accordance with the State Operations Manual (F225 and F226) on 10/10/13. In-service training was initiated on 10/10/13 and completed on 10/12/13, for 100 percent of facility employees by the Staff Development Coordinator (SDC).</p> <p>The AOC further revealed the Administrative staff, including the Administrator, DON, and SSD, was counseled by the Corporate Officer and retrained by the Staff Development Nurse on 10/10/13 on the Abuse policy.</p> <p>Further review of the AOC revealed the facility would ensure continued compliance through the completion of a daily Continuous Quality Improvement (CQI) form to be reviewed during the daily CQI meeting to ensure all concerns/grievances have been thoroughly reviewed and all issues have been addressed per policy with appropriate reporting to the state agencies. The CQI form will be reviewed daily by the Administrator and bi-weekly by the Managing Partner. In addition, the AOC noted an Abuse Log would be completed daily by the SSD, DON, ADON, MDS Nurse, or NS and reviewed daily by the Administrator, DON, or designee. The Administrator would provide daily oversight to ensure all allegations of abuse, neglect, misappropriation of property identified will be investigated in a timely manner, involved staff was immediately suspended, and state agencies were notified immediately. The AOC further indicated the Allegations of Abuse Log would be</p>	F 520	<p>F-520 Continued...</p> <p>Staff that worked with CNA #4 was interviewed to determine if they knew that CNA #4 would tell residents not to put on the call light. Staff statements reflect that they had never witnessed CNA #4 speaking in that manner to any resident or asking them not to put on their call lights. Interviews with other residents revealed that they had never been told to not put on their call lights by CNA #4. It was determined that CNA #4 had established a pattern of complaints and review of past counseling's related to not following care plans, such as resident to be transferred by two person assist with the use of Hoyer lift, it was determined that the potential for abuse and neglect was present if she remained in the facility. A proactive approach was taken in this allegation to terminate the employee preventing any potential abuse, neglect, exploitation or misappropriation from this individual in the future, (Substantiated, Employee Terminated 10/21/2013).</p> <p>RSD #9</p> <p>Complaint reopened, 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: (RSD #9) states that (employee) refused to take her to the bathroom, employee was suspended and a thorough investigation was completed. Conclusion: Additional investigation revealed that (Employee) did not refuse to take to the toilet as evident by interviews with staff members that were present at the time and residents roommate and residents that lived on the same unit as RSD #9.</p> <p>F-520 Continued...next page</p>		

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F 520	<p>Continued From page 74</p> <p>utilized to track/trend reported allegations and would be reviewed monthly with the QA Committee.</p> <p>**The surveyors validated the corrective action taken by the facility as follows:</p> <p>Review of the facility's documentation revealed a 100 percent audit had been conducted of all in-house residents on 10/11/13 by the DON to identify any potential signs or indicators of abuse, neglect, or misappropriation. A review of the daily census for 10/11/13, verified all residents had been assessed for abuse, neglect, and misappropriation. Review of the Abuse/Complaint question assessment tool and interviews conducted with residents and facility staff revealed no signs or symptoms of abuse were evident. A review of the facility's investigations revealed the facility had reopened the allegations identified in the AOC and had conducted a more thorough investigation which included suspension/termination of the alleged perpetrators and appropriate reporting of each allegation immediately to the state agencies. Interview conducted with the DON on 10/23/13 revealed the investigations had been reopened and witness interviews and other pertinent data had been used to determine if the allegation was substantiated or unsubstantiated. The DON also provided evidence that protection had been provided for the residents during the investigation and the allegations had been reported to the state agencies as indicated in the AOC.</p> <p>Review of the facility's Abuse policy revealed the policy had been revised to reflect interventions to be utilized to deal with reporting, protection, and investigation of all allegations of abuse. A review</p>	F 520	<p>F-520 Continued...</p> <p>Present if she remained in the facility utilizing revised abuse policy. A proactive approach was taken in this allegation to terminate the employee preventing any potential abuse, neglect, exploitation or misappropriation from this individual in the future, (Substantiated, Employee Terminated 10/21/2013).</p> <p>RSD #9: Complaint reopened, 10/13/13, Date reported 10/13/13, completed Date: 10/17/13: SRNA was suspended by DON and an investigation was conducted which included interviews with Staff that were present and residents on the same unit. A physical assessment was conducted, that revealed no bruising, skin tears or any other signs of abuse. Conclusion: Determination made that accused SRNA did not squeeze (Resident) after interview with SRNA and (Resident). (Resident) stated that she simply did not like the way she was transferred that time. Noted, (Resident) has diagnosis of severe rheumatoid arthritis and continuous generalized pain of entire body. In addition to: Obsessive Compulsive Disorder, Depression and Anxiety requiring mild and soft transfers. Allegation was unsubstantiated; SRNA was re-educated on proper transferring techniques with this resident).</p> <p>F-520 Continued...next page</p>	

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F 520	<p>Continued From page 75</p> <p>of the facility's in-service sign-in sheets, pre/post tests, and interviews with staff (RN #1, LPN #10, LPN #11, CNAs #13, #14, #15, and #16, Housekeeping Staff Members #1 and #2, and Dietary Staff Member #1) on 10/23/13, verified staff had been in-serviced on 10/10/13, 10/11/13, 10/12/13, 10/14/13, 10/15/13, 10/17/13, 10/19/13, and 10/21/13, as stated in the AOC. Staff further revealed they had been in-serviced on the revised/updated abuse policy to include timely reporting of any allegation of abuse/neglect by the use of a pre/post test. The revised abuse policy material included educating staff on how to identify, assess, complete thorough investigations, and timely reporting.</p> <p>Review of the Performance Improvement Forms dated 10/10/13 verified counseling was provided for the Administrator, DON, and the SSD by the Corporate Officer. In addition, review of the in-service records dated 10/11/13 revealed retraining related to the Abuse policy was provided to the Administrator, DON, and the SSD on 10/11/13. Interviews conducted with the Administrator, DON, and the SSD on 10/23/13 confirmed counseling and reeducation had been provided as stated in the AOC.</p> <p>Interviews conducted with members of the IDT team (Administrator, SSD, DON, UC, Dietary Manager, Activities Director, SDC, and MDS Nurse) on 10/23/13, revealed the allegations of abuse, neglect, exploitation, and misappropriation were reviewed daily during the IDT meeting to ensure the allegations/concerns were appropriately reported, investigated, and resident protection provided.</p> <p>Review of the Abuse/Complaint question</p>	F 520	<p>F-520 Continued...</p> <p>SRNA was able to demonstrate how transfer took place with RSD #9 and was directed on how to better transfer with this resident by the DON. Rsd with diagnosis of severe rheumatoid arthritis and continuous generalized pain of entire body. In addition to: Obsessive Compulsive Disorder, Depression and Anxiety RSD #9, as related to her diagnosis of Obsessive Compulsive Disorder requests to be toileted every 15-30 minutes. She was placed on a Bowel and Bladder Plan by her Physician with interventions including; toilet every 2 hours at specific times. (Employee) was following the plan of care set forth by the Physician, and encouraging RSD #9 to wait until the set time to go. The bowel and bladder plan has been care planned and discussed many times with RSD #9. She is in agreement with the plan. She still continues to ask to go the toilet every 15-30 minutes. Staff continues to re-educate her on a daily basis as to her planned program set forth by her physician. Note: (Resident) has been on the scheduled Bowel and Bladder Program since 1/18/2013. The Allegation was Unsubstantiated, (Employee) was re-educated as to (Resident) specific Bowel and Bladder Program and proper toileting techniques.</p> <p>F-520 Continued next page...</p>		

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F 520	Continued From page 76 assessment tool and interviews conducted with Residents #3, I, J, K, L, and M on 10/23/13, verified staff had interviewed them daily from 10/11/13 to 10/18/13 to determine if any abuse had occurred. Further review of the abuse/complaint questionnaire revealed the Administrator, DON, and Managing Partner reviewed the information daily. Interview conducted with the Administrator on 10/23/13, at 5:45 PM, revealed he reviewed the Abuse Log daily and any identified discrepancies were corrected immediately to ensure all allegations of abuse, neglect, or misappropriation were investigated and reported, and protection for residents was provided appropriately. The Administrator stated the Abuse log would be utilized as a tracking/trending tool to report any trends and problems to the QA Committee.	F 520	F-520 Continued... RSD "B" Employee was suspended immediately and an investigation was completed by interviewing staff that were present during meal time as well as other residents that were present. A physical assessment was completed and no adverse affects were noted, lungs were clear, afebrile, vital signs were normal and resident was in no distress. Conclusion: RSD has worked with Speech Therapy and has had a five (5) modified Barium Swallow studies from 6/2012 to 5/2013. The physician is aware and has declined the use of a feeding tube. The RSD is care planned for choking and coughing episodes during meals. Staff is educated to stop feeding and allow him to "Cough and Clear" while being monitored by the feeding staff during these episodes. Unsubstantiated and re-educated as to proper feeding techniques and the potential for this resident to aspirate during feeding and when to alert nursing staff to potential aspiration. Continued on Appendix "B" F-520...		

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Appendix "A" F-490 Continued...

...trace, the facility had replaced the monies. The policy of the facility is that residents are encouraged not to keep money on their person and to have the business office keep their money in the safe and they could get it at any time during the week or weekend. RSD #9 reported \$5.00 was missing on 11/05/12 interviews of staff and other residents did not reveal any information, money was replaced by facility, no evidence of anyone haven it taken was determined. Resident #11 reported \$5.00 was missing from his/her chest at the resident's bedside on 11/20/12, interviews with staff and other residents did not reveal any information, money was replaced by facility, no evidence of anyone haven it taken was determined. On 11/01/12, Resident D reported to the SSD he/she was missing \$4.36, interviews with staff and other residents on the unit did not reveal any information, money was replaced by facility, no evidence of anyone haven it taken was determined. Resident E reported he/she had \$30.00 missing since 11/04/12, interviews with staff and other residents on the unit did not reveal any information. , money was replaced by facility, no evidence of anyone haven it taken was determined. Monies were replaced by facility for residents F and G as well, interviews with staff working at time the monies went missing and other residents did not reveal any information no evidence of anyone haven it taken was determined.

2. The facility through interviews with all residents and physical assessments performed on all residents in the facility The facility through interviews with all residents by DON, MDSN and ADON and physical assessments performed by DON on all residents in the facility. There were five (5) allegations of abuse (1. Rough care in the past, 2. fearful of nurse, 3. RSD-RSD doesn't treat me with respect 4. Fearful of minister 5. Rough care provided), six (6) Misappropriations (1. Missing watch 2. Missing necklace 3. Missing blanket 4. Missing clothes 5. Picture taken from room 6. Missing shirt), Two (2) neglect allegations (1. SRNA refused to take rsd to bathroom, 2. RSD states did not receive shower), issues that was determined to exist. Each resident was protected, any potential perpetrators were removed from the resident care area, each resident was physically assessed from head to toe immediately, all appropriate state agencies were notified immediately and each case was investigated by use of interviews with staff, Residents, family members and other persons as needed. Completed October 11, 2013.
3. Systemic changes such as; Quality Assurance/Risk Management Policy was updated October 13, 2013 to include specific oversight of Abuse, Neglect, Misappropriation oversight and input from Medical Director. **(See Exhibit # 10: Quality Assurance Policy)**. In-service/re-education training implementation began for 100% of employees, specifically including Administrator, DON and Social Services Director, immediately on October 10, 2013 by SDN, when the discovery was made and the potential for systemic failure was identified. **(See Exhibit #2: Resident Abuse Training Materials F-225/F-226, Abuse Policy revision date 10/10/2013 and attendance records)**. The in-services, education and policy changes were completed on October 12, 2013 through one on one training with every employee by Staff Development Nurse **(See Exhibit # 4: Abuse Training Verification Log)**. No employee was/will be allowed to work until completion of training (If on Leave or Vacation training with validation of competency will be completed before allowing return).
4. An Abuse/Complaint assessment tool was developed and implemented on October 11, 2013, **(See Exhibit # 1; Abuse/Complaint Assessment Tool)**. All alert and oriented residents were interviewed by DON, SSD, MDSN, UCN, SDC and MRD for any statements/evidence of suspected abuse, concerns, neglect, exploitation or misappropriation. In order to ensure all violations involving mistreatment, abuse, neglect or misappropriation of resident funds or property are, investigated thoroughly through interviews with staff and residents, head to toe physical assessments, record reviews, residents are protected and allegations are reported timely to state agencies, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Nurse(SDC), Social Services Director(SSD), Minimum Data Sets Nurse(MDSN), Unit Coordinator Nurse (UCN), Nurse Supervisor(NS) or designee will audit by utilizing Abuse/Complaint Assessment Tool daily x 1 week, then weekly x 4 weeks, then monthly x 1 month, longer if 100% compliance of process is not achieved. Beginning October 11, 2013. The Assessment Tool will be utilized on weekends as well. The weekend completion will be performed by the NS. If NS is unavailable then the DON, ADON, MDSN or SDC will be responsible to carry out this task. The Administrator will provide oversight daily, including weekends, by discussion and/or reviewing and initialing the audits after review to ensure residents were protected, reporting was timely and the investigations were thorough through interviews with staff and residents, physical head to toe assessments, record reviews. In addition, the Managing Partner will review twice weekly with the Administrator in an informal format to ensure that allegations are reported timely, residents are protected, receive appropriate assessments, perpetrators are suspended or terminated and a thorough investigations are being performed which includes through interviews with staff and residents, head to toe physical assessments and record reviews, any alleged abuse, neglect; misappropriation of funds identified will be investigated in a timely manner to ensure the resident's safety with an assessment for any physical or psychosocial issues. Immediate suspension of staff involved and timely notification of state agencies will be completed immediately, by SSD, DON, ADON, MDSN, SDC, Administrator, NS or UCN. The DSS, DON, Administrator, ADON, MDSN or NS will conduct an abuse monitor, **(See Exhibit # 7: Village of Lebanon, LLC**

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Abuse Monitor), weekly x 4 weeks, then every month for three months, then quarterly thereafter and report to Quality Assurance Committee for guidance, direction and oversight. In Addition, The DSS, DON, ADON, MDSN or NS will complete an Allegations of abuse, neglect or misappropriations Quality Assurance Log to be reported on a daily basis to the IDT Committee (Morning Meeting) and will be reviewed daily by the Administrator or designee (SDN) and Director of Nursing or designee (ADON/MDSN) for Tracking and trending such as, discovery of any trends in the report, allegations occurring on the a certain shift, day, night, evening, whether or not a certain employee, event or situation had developed a pattern that would require additional investigation such as, interviews with staff and residents, head to toe physical assessments, record reviews. In Addition, The DSS, DON, ADON, MDSN or NS will complete an Allegations of abuse, neglect or misappropriations Quality Assurance Log to be reported on a daily basis to the IDT Committee (Morning Meeting) and will be reviewed daily by the Administrator or designee (SDN) and Director of Nursing or designee (ADON/MDSN) for Tracking and trending such as, discovery of any trends in the report, allegations occurring on the certain shift, day, night, evening, whether or not a certain employee, event or situation had developed a pattern that would require additional investigation. This log will be turned in monthly to the QA committee for review and oversight, (See Exhibit #6: Allegations of Abuse, Neglect, Misappropriations Quality Assurance Log) The Abuse reporting form was revised on October 14, 2013 by the IDT. (See Exhibit # 9: Abuse Reporting/Investigation Worksheet), which will have oversight by Assistant Administrator and/or Administrator on a daily basis with oversight by Medical Director through Monthly Quality Assurance. Quality Assurance/Risk Management Policy was updated October 13, 2013 to include specific oversight of Abuse, Neglect, Misappropriation oversight and input from Medical Director.(See Exhibit # 10: Quality Assurance Policy).

5. F-490 Completion Date: 11/01/2013

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Appendix "B" F-520 Continued...

The facility replaced Residents Monies missing for the following residents #9, #11, D, E, F, and G when incident occurred. Employees were interviewed by the Director of Social Services, to determine events surrounding the missing monies. Residents that live on the same units aside from the RSDs listed above were interviewed. Residents were also interviewed at the time the monies went missing and there was no evidence found to imply that impropriety had occurred other than the disappearance of monies without reason or trace, the facility had replaced the monies. The policy of the facility is that residents are encouraged not to keep money on their person and to have the business office keep their money in the safe and they could get it at any time during the week or weekend. RSD #9 reported \$5.00 was missing on 11/05/12 interviews of staff and other residents did not reveal any information, money was replaced by facility, no evidence of anyone haven it taken was determined. Resident #11 reported \$5.00 was missing from his/her chest at the resident's bedside on 11/20/12, interviews with staff and other residents did not reveal any information, money was replaced by facility, no evidence of anyone haven it taken was determined. On 11/01/12, Resident D reported to the SSD he/she was missing \$4.36, interviews with staff and other residents on the unit did not reveal any information, money was replaced by facility, no evidence of anyone haven it taken was determined. Resident E reported he/she had \$30.00 missing since 11/04/12, interviews with staff and other residents on the unit did not reveal any information. , money was replaced by facility, no evidence of anyone haven it taken was determined.

2. Through interviews with all residents by DON, MDSN and ADON and physical assessments performed by DON on all residents in the facility. The facility through interviews with all residents by DON, MDSN and ADON and physical assessments performed by DON on all residents in the facility. There were five (5) allegations of abuse (1. Rough care in the past, 2. fearful of nurse, 3. RSD-RSD doesn't treat me with respect 4. Fearful of minister 5. Rough care provided), six (6) Misappropriations (1. Missing watch 2. Missing necklace 3. Missing blanket 4. Missing clothes 5. Picture taken from room 6. Missing shirt), Two (2) neglect allegations (1. SRNA refused to take rsd to bathroom, 2. RSD states did not receive shower), issues that was determined to exist. Each resident was protected, any potential perpetrators were removed from the resident care area, each resident was physically assessed from head to toe immediately, all appropriate state agencies were notified immediately and each case was investigated by use of interviews with staff, Residents, family members and other persons as needed. Completion of assessment and determination of residents affected completed October 11, 2013.
3. Systemic changes such as; Quality Assurance/Risk Management Policy and Facility Abuse Policy were updated October 13, 2013 and October 10, 2013 to include specific oversight of Abuse, Neglect, Misappropriation oversight and input from Medical Director.(See **Exhibit # 10: Quality Assurance Policy**). In-service/re-education training implementation began for 100% of employees, specifically including Administrator, DON and Social Services Director, immediately on October 10, 2013 by SDN, when the discovery was made and the potential for systemic failure was identified. (See **Exhibit #2: Resident Abuse Training Materials F-225/F-226, Abuse Policy revision date 10/10/2013 and attendance records**). The in-services, education and policy changes were completed on October 12, 2013 through one on one training with every employee by Staff Development Nurse (See **Exhibit # 4: Abuse Training Verification Log**). No employees was allowed to work until completion of training (If no leave or Vacation training with validation of competency will be completed before allowing to work).
4. The development of an Abuse/Complaint Assessment tool and the implementation on October 11, 2013, (See **Exhibit # 1; Abuse/Complaint Assessment Tool**). All alert and oriented residents were interviewed by DON, SSD, MDSN, UCN, SDC and MRD for any statements/evidence of suspected abuse, concerns, neglect, exploitation or misappropriation. In order to ensure all violations involving mistreatment, abuse, neglect or misappropriation of resident funds or property are, investigated thoroughly through interviews with staff and residents, head to toe physical assessments, record reviews, residents are protected and allegations are reported timely to state agencies, the Director of Nursing (DON), Assistant Director of Nursing (ADON), Staff Development Nurse(SDC), Social Services Director(SSD), Minimum Data Sets Nurse(MDSN), Unit Coordinator Nurse (UCN), Nurse Supervisor(NS) or designee will audit by utilizing Abuse/Complaint Assessment Tool daily x 1 week, then weekly x 4 weeks, then monthly x 1 month, longer if 100% compliance of process is not achieved. Beginning October 11, 2013. The Assessment Tool will be utilized on weekends as well. The weekend completion will be performed by the NS. If NS is unavailable then the DON, ADON, MDSN or SDC will be responsible to carry out this task The Administrator will provide oversight daily, including weekends, by discussion and/or reviewing and initialing the audits after review to ensure residents were protected, reporting was timely and the investigations were thorough through interviews with staff and residents, physical head to toe assessments, record reviews. In addition, the Managing Partner will review twice weekly with the Administrator in an informal format to ensure that allegations are reported timely, residents are protected, receive appropriate assessments, perpetrators are suspended or terminated and a thorough investigations are being performed which includes through interviews with staff and residents, head to toe physical assessments and record reviews, any alleged abuse, neglect; misappropriation of funds identified will be investigated in a timely manner to ensure the resident's safety with an assessment for any physical or psychosocial issues. Immediate suspension of staff involved and timely notification of state agencies will be completed immediately, by SSD, DON, ADON, MDSN, SDC, Administrator, NS or UCN. The DSS, DON, Administrator, ADON, MDSN or NS will conduct an abuse monitor, (See **Exhibit # 7: Village of Lebanon, LLC Abuse**

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Monitor), weekly x 4 weeks, then every month for three months, then quarterly thereafter and report to Quality Assurance Committee for guidance, direction and oversight. In Addition, The DSS, DON, ADON, MDSN or NS will complete an Allegations of abuse, neglect or misappropriations Quality Assurance Log to be reported on a daily basis to the IDT Committee (Morning Meeting) and will be reviewed daily by the Administrator or designee (SDN) and Director of Nursing or designee (ADON/MDSN) for Tracking and trending such as, discovery of any trends in the report, allegations occurring on the a certain shift, day, night, evening, whether or not a certain employee, event or situation had developed a pattern that would require additional investigation such as, interviews with staff and residents, head to toe physical assessments, record reviews. In Addition, The DSS, DON, ADON, MDSN or NS will complete an Allegations of abuse, neglect or misappropriations Quality Assurance Log to be reported on a daily basis to the IDT Committee (Morning Meeting) and will be reviewed daily by the Administrator or designee (SDN) and Director of Nursing or designee (ADON/MDSN) for Tracking and trending such as, discovery of any trends in the report, allegations occurring on the certain shift, Day, night, evening, whether or not a certain employee, event or situation had developed a pattern that would require additional investigation. This log will be turned in monthly to the QA committee for review and oversight, **(See Exhibit #6: Allegations of Abuse, Neglect, Misappropriations Quality Assurance Log)** The Abuse reporting form was revised on October 14, 2013 by the IDT. **(See Exhibit # 9: Abuse Reporting/Investigation Worksheet)**, which will have oversight by Assistant Administrator and/or Administrator on a daily basis with oversight by Medical Director through Monthly Quality Assurance. Quality Assurance/Risk Management Policy was updated October 13, 2013 to include specific oversight of Abuse, Neglect, Misappropriation oversight and input from Medical Director.**(See Exhibit # 10: Quality Assurance Policy)**.

5. **F-520 Completion date: 11/01/2013**